CLINIC FOR WOMEN 3607 W 16TH STREET, SUITE 2B INDIANAPOLIS, INDIANA

<u>Indiana</u> S	tate Department of He	alth			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING;		COMPLETED
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	Facility #0111133	•		,	
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Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Indiana State Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING_ 04/04/2018 011133 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3607 W 16TH ST STE 2B **CLINIC FOR WOMEN** INDIANAPOLIS, IN 46222 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) T 000 INITIAL COMMENTS T 000 This visit was for a State licensure survey. Dates of survey: 4/2/18 to 4/3/18 Facility #0111133 Clinic For Women is in compliance with 410 IAC 26-4 through 410 IAC 26-18, Abortion Clinic Licensure Rules. QA: 4/5/18 Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Indiana State Department of Health Personnel Document Review

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Abortion Clinic:	CFN	Date:

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ABORTION CLINIC ADMINISTRATIVE TOUR **FACILITY SURVEYOR** MED DIR MANAGER **TOUR:** DATE Posting of license Pantry/nourishment area Janitor closet Housekeeping - All over Preventative Maintenance √ Storage Areas West & Flammable agents Tank storage and secured ✓ Overall maintenance Adequate battery powered lighting and equipment Medical record storage Laundry Services Safety Lab area, as applicable Chemical use and storage - House Keep + Aland Refuse/infections waste - (x/ws. COMMENTS/INTERVIEWS:

Facility Name_	Pini	10	Women	
Surveyor		<u>)</u>		Date

ABORTION CLINIC DOCUMENT REQUEST - CREDENTIAL FILE REVIEW

		DOCUMENT REQU	& date				· & Vaif	ØB	ρ		
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Abortion Clinic

	Administrative Document Request
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	List of credentialed staff for plan house
	List of credentialed staff for blat portal List of non-nursing Personnel for blat provided Library Alexandry
	Ownership—copy of articles of incorporation
8. 10	Quality assurance plan and documents to include all services/function/contracts
2 Low Se	List of contracts with scope and nature of services
y, <i>Na</i> 4065<	☐ Constitution and bylaws of governing body (if applicable) ☐ Armed # 7/21/17, 4/14/17 ☐ Minutes of governing body (if applicable)
1	☐ Minutes of governing body (if applicable) .2016 125/17
	☐ Process for reporting health professionals
	☐ Written policy addressing internal review of unusual occurrences and disasters
	/
	Medical Staff Rules including;
	☑ Procedures for emergency, initial treatment, transfer
	☐ History and physical
	Authentication of orders, who may take verbal orders
	☐ Policy and procedure for communication with and timely response of physicians concerning a
	pt/emergency
	☑ Health care worker practice problems
	☐ Physician Credentialing (if physician performs procedures): verify admitting privileges in
	writing OR a written agreement with another physician with admitting privileges. The
	document(s) must be present in the clinic.
	document(s) must be present in the clinic.
	Medical records policies including;
	☐ Policies assuring documentation of care and services provided
	Lypolicies for safeguarding records from sources of damage
	Maintenance of records for appropriate time frame
	Authentication and security of record
	Use of plain paper fax
	Confidentiality
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	Dietary policies (if applicable)
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	Lab policies including;
	CLIA certificate or waived
	☐ Quality control and QA policies for complexity of tests
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	Physical plant/ Safety policies including;
	☑ Preventative maintenance policies/logs
	☐ Repairs and electrical leakage checks
	☐ Housekeeping and infectious waste policies
	☐ Equipment inspection
	□ Vermin Control
	☐ Building operations
	Chemical substance use/storage
	☐ Surgical waste disposal
	☐ General housekeeping
	☐ Fire control plan AND Evidence of state or local fire inspection \$\frac{\psi}{5}\line{17}\$
	☐ Emergency/disaster preparedness
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Indiana State Department of Health

Abortion Clinic Human Resources Request Form

Person	nel files should i	nclude:
9	Prior education,	,

- position/title,
- date of hire,
- e license/certification,
- initial orientation,
- in-servicing/education,
- job description,

- competencies
- current CPR status,
- most recent evaluation,
- physical exam/tests,
- two step PPD,
- Immunizations per facility policy.

PLEASE, Mark/label with tab on each of the above areas per file or have a staff member familiar with files available for review process. THANK YOU.

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Indiana State Department of Health Personnel/physician identifier Table

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PLANNED PARENTHOOD OF INDIANA AND KENTUCKY 8645 CONNECTICUT STREET MERRILLVILLE, INDIANA

PRINTED: 09/06/2018 FORM APPROVED Indiana State Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING_ 011116 03/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8645 CONNECTICUT ST PLANNED PARENTHOOD OF INDIANA AND KENTUC! MERRILLVILLE, IN 46410 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) T 000 INITIAL COMMENTS T 000 This visit was for a State licensure survey. Facility Number: 011116 Dates of Survey: 3/19/2018 to 3/21/2018 Planned Parenthood of Indiana - Merrillville Clinic is in compliance with 410 IAC 26, Abortion Clinic Licensure Rules. QA: 03/23/2018

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Facility Name	Planned Parenthood Of IN & KY- Merrillville	Surveyor Name	Grace Russell, RN
Provider Number	Surveyor Number	14445	Discipline PHNS
Observation Dates:	From 3/19/2018 To	3/21/2018	•
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Memilialle Parenthood 3/19-31/2018

Abortion Clinic Administrative Document Request

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DiPolicies for safeguarding	ncluding; mentation of care and services provided ng records from sources of damage s for appropriate time frame	FORMULARY revised + 3/12/201	₽ 8
Laundry policies — ON Dietary policies (if applic	SHE able)—) only Gop, jude, snocks offer	1	
Lab policies including; CLIA certificate or wa Description Quality control and QA	CDD and Labbrep ived a policies for complexity of tests		
Physical plant Safety pol IV Preventative maintenant Repairs and electrical I IV Housekeeping and infe IV Equipment inspection IV Yermin Control (OP) IV Building operations— II Surgical substance us IV Surgical waste disposa	nce policies/logs enkage checks ctious waste policies		
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U	Facility Name_	Planned	Parent	-hood.	/	Memilluille
	Surveyor	GRACE PUS	sell for,	PHNS	Date	3/19-21/2018
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ABORTION CLINIC DOCUMENT REQUEST – CREDENTIAL FILE REVIEW

		MD#	MD Name	Appt/ Reappt	-IN MD License	IN CSR	DEA Registra	Edu/Train Exper	Priv	CPR	Perf Rev
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Facility Name Planned Parenthood	- Memiliale
Surveyor GRACE PUSSELL PU. PA	NS Date 3/19-3/21/18
ABORTION CLINIC DOCU QA/PI MÖNIT	
Monitor Standard Y N Y N	QA Reports Y N
Biohazardous Waste (Swx)	——————————————————————————————————————
Biomedical PM Y KARMedical	
Housekeeping V	Y (Performance Co)
Lab Y Lab Corp +CB	o /
Laundry/Linen V	America dans de al constitución de la Constitución de America de A
Medical Records \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
Maintenance Y (Internation Y	and external for property of farkway
Nursing V	Mechanical
Pharmacy V (Internal) in place Y	
Security V	our d central December
Discharges V	Y CENTRAL PROBLEMY
Transfers V	<u> </u>
Infection Control Y	<u> </u>
Response to Patient Emergencies /	
Medical & Medication Errors Y	
Reportable Events	
Semi-annual governing board meetings which incl	uded QA&I reports
Peot rentral = Optail /	phr call service Centratel
HVAC-1 Maint (Packway / mechanisal)	Os + Proxair v
(· MAGININ ML)	Sonogram J GE DK

	ABORTION CLINIC ADMI			
FACILITY Planned Pe	urenthood Hrillsurv	EYOR GEACE	fusiell RN, PHMIS	
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Housekeeping Preventative Mainten Storage Areas (Mainten Flammable agents	n)	Pa	reduce for #1/	
Medical record storas	vered lighting and equipmen	, nt	table () Protet 3/6/18 Suction Merchine	i
Safety Lab area, as applicab Chemical use and sto	le/eue wash rager	Nsinfeat	Procedure for #21/ equip some As from A1- pm'd 3/6	lis
her fres Relise/Intections was Her force ked room Book for meds emorg lut COMMENTS/INTERVIEW		lugi s	Other Us Machine / p.	~ 3/6/18
wx Harmedy Exit	STANK / IN beel above		non-sprinkter Tire extiguester Smoke detecti Jighted exit s	u~ res/ igns/
Scorles PM 3/6/18/ PM USMaghab (12)	US Room (H1) exam trate pm 3/6/18/	Disinfect log/ No fraces- Sterps/	Ezkill Clonok Wi	pes /
3/6/18/	machine pm 3	6 18	Spore Lesting (& 7 days to	Autoclave (Stepilma) healthlink
- Phogram / Lemplogry no issues	rt educat Material	Ijni /	testrouter 1/4/18, 1/11/18	Bac 3, 1/18/18
Hope POC/lab room/ instruments & speculiums	Maxizyn for Alean Suction 1	urg	1/25/18, 2/1/18, 2/27/18, 2/1/18 (all same do	1, 3/8/18 ates)
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Facility Name_	Planned	Panenth	ood-	Memilinik		Morrow consequence and a second secon
Surveyor	Gene	Russell	en,	PHWS	Date_	3/19-3/21/18

ABORTION CLINIC DOCUMENT REQUEST - PHYSICAL PLANT WORKSHEET **EQUIPMENT**

Pype	Tag 0496	Tag 0408	Tag 0410 Triennial Re	view	
Heating	1/	6/30/17	ſ		
Ventilation	W	by choos	lerrow/	problems	
Air Conditioning		i hando - A		IG ON LOOP	
Emergency Generator-					
Emerg Power Source				and the second s	
Fire Alarm	1 K	porsen chape	BUN 12/5/17	-A-J-Gin Am	ded
Smoke Defector	1 (battery)	и	и	and fire flours	Sun
Sprinkler System					
		Tag 0416 PM	Tag 0418 Electr Check	Tag 0418 Triennial Review	<u> </u>
Anesthesia Machine					
Cardiac Monitor					
Centrifuge		V 3/6/18			
Patib/AED		136/18			
Emerg Call Code Syst	no pull ands	- I overhead	paging pyston	n-1	
Patient Exam Light	1 James	13/6/19			_
Patient Scale	1	13/6/18			
Recovery Chair / M	de electrical -	-	Mark Mark Mark Mark Mark Mark Mark Mark		_
Sterilizer /		13/6/18	-		
Suction Machine 42		13/6/18	.w.		
Surgical/Exam Table /		13/6/18			
Ultrasound 42		13/6/18	1/		
33 / Landalinia	1	1 1 11			

Microscope 36/18/ NA-do not have equipment

NR - not responsible, as equipment is building-wide & maintenance responsibility is by lessor

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Shift 2	and were				
Shift 3	- Leave - Leav				

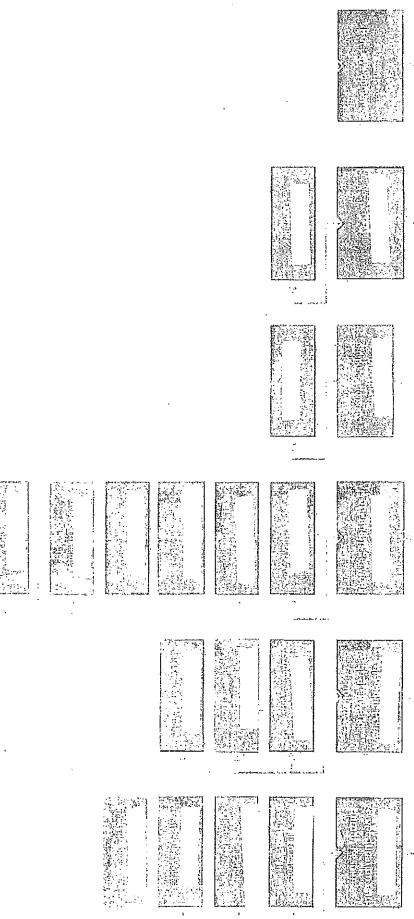
Abortion Clinics usually have only 1 shift

Surveyor_ GRA	nned farenthood Le Russell for PH	WS Date	: 3/19-3/21/2018	}
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PPINK Revised 11/17

Surveyor GRACE	. Kussolif	n, PHNS	Date 3	19-3/21/2018	}
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Abortion-Clinic Nursing Document Request

Patient list/register for Nov 2017 to Feb 2018
List of all Nursing Personnel including agency for Same
Complaint Log for Same
Incident Reports for Same
Pt trsf out-same
Personnel policies including;
☑ Policy for control of communicable diseases includes specific to TB
☑ Orientation and training of new employees, contract and agency personnel
CPR policy
Mannual in-service requirements
Annual competency for nursing and other personnel performing lab tests
Patient care/nursing policies and procedures including;
Patient care/nursing policies and procedures including; Composition of and meeting minutes for the patient care personnel committee (Evilused) Reliable method of ID verileved
Instruction for follow up care and transportation—to include counseling, RH type and
administration of Rhogam
Reporting of post procedure complications and follow up
☑ Cleaning and sterilization of reusable equipment
Infection control program and policies including;
Composition and meeting minutes of infection control committee
Provision for active and effective Infection Control Program
Sterilization policies and procedures including;
☑ Instructions for loading, operating, cleaning and maintaining sterilizers
Instructions for cleaning packaging, storing, labeling and dispensing of sterile supplies
Records of sterilization cycle and results of biological indicators in testing sterilization
Cleaning of environmental surfaces contaminated by blood or infectious material
Anesthesia policies including;
Safety rules to be followed
☐ Safety training required of personnel ☐ Preanesthesia, intraoperative and post anesthesia policies and requirements
• • • • • • • • • • • • • • • • • • •
Pharmacy services policies including; — GYACE
☐ Records of stock supplies and accounting of all items
Policies for drug handling, storing, labeling dispensing and administration
Reporting of adverse reaction and medical errors
Storage and security—Wedicotion Room
Tormulary Transfer of the Control of
List of available emergency drugs
List 13/4/15 List return visits > incomplete - Same
List return kisits > incomplete - sume
1 ist and intentions & same.

ABORTION CLINIC NURSING TOUR

Facility # 011116

F.	ACILITY	Planned Paren	thood Merrilla	ville	SURVEYOR TERMIN BORDER KAN
M	ED DIR		MANAGER_		_TOUR: DATE_3/20/18 TIME
S'	TAFFING:	R.N	LPN	Tech	Ratio:
	Dress Adeq Clear	c pattern ing areas/staff uate supplies/s utility FPROCEDUI		<u>.</u>	Soiled utility Linen Storage Handwashing sinks/toilets preventive maintenance Sorueyor Notes
1	Scrul Dress Emer Oxyg Résu Defit Card	agea code adheren gency call system en/humidifier scitation equip orillators (if IV ac Monitors (i	em bottles	d) used)	Suction Equipment (if IV Sedation is used) Other supplies/equipment specified by medical staff (if IV Sedation is used) IV equipment Anesthesia agents used Sharps disposal Medication and narcotic storage/drug areas/stock supplies
	Steri	izers	ent/sterilization I indicators types — (Ev)	*	Surveyor Notes 1/t tour
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Indiana State Department of Health

Abortion Clinic Human-Resources Request Form

competencies

 position/title, date of hire, license/certification, initial orientation, in-servicing/education, job description, 	 current CPR status, most recent evaluation, physical exam/tests, two step PPD, Immunizations per facility policy.
PLEASE, Mark/label with tab with files available for review p	on each of the above areas per file or have a staff member familiar process. THANK YOU.
Nursing:	
1. 2. 3. 4. 5. 6. 7. 8. 9.	
Administration: 1 2	

Monther PN

Personnel files should include:
Prior education,

Indiana State Department of Health Personnel Document Review

Not required facility

Facility # 011116 Annual

Abortion Clinic: Planned Parenthood - Merrillville Date: March 19-21 2018

İ	Name/Class	Prior Educ	Hire Date	Lic/	Orient	_ In- service	CPR	Last eval	Compe tency	Phy Exam	Immun	PPD 2 step	Other Crimhx
渊	l	N	4/3/17	cert		SCIVICE -	V -	11/17/19		X		1/	<i>√</i>
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Indiana State Department of Health Patient/Record Identifier Table

Name of abortion clinic: Planned Parenthood-Merrillville

Date of survey: March 19-21 2018

Type of survey: State Licensure

Patient's name or medical record number	Number assigned by surveyor to patient's name or medical record number
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ABORTION CLINIC MEDICAL RECORD REVIEW

	PT ID#	PT ID#	PT ID.#	PT 1	PT ID#	PT ID#	PT TD#	PT ID#	PT ID#-	PT . ID#
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Name	<u> </u>									
Age Address					17	1.7.	\ \	V	1	V
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On-site proof of pregnancy as evidenced by a pregnancy	1	√	1		√ .	V	\checkmark	W.	1 /.	V,
test, a copy of a pregnancy test or an ultrasound Verification and documentation of gestational age	1	1	3/	1/2	1	1	V	V.	1	V
Verification and documentation of gestational age Hematocrit or hemoglobin	Z	Ž	1	1/1	1	V	1/1	Vz	V	1
Rh typing	14	TV	V,_	V	V	(-)	Vr	W	\ \/ .	Ι.
Completion of the abortion documented by ultrasonography	1			3/				1	1	V,
or other clinical means		Y	\	1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	 		-/-	1	1 1
Provision of follow-up examination and services	\ <u>\</u>	1 ×	1 7	1	×	17	1	1	V	1
eanesthesia evaluation within forty-eight (48) hours before a surgical contion	X	l X	I X	I X	X	X	X	X		LX.
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Vital signs	11	V	\ V	V,	\ <u>\</u>	V j	ν,	1 V/-	V	V/
Allergics	V,	V	1/	V/	V	V	V	1V/	1/	1 4/
Any significant risk factors	×/	V	 	 	14	17,	1	1-4	14/	1.7
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ntries related to anesthesia administration	1-	1	1-	1	1	17	7	17	+	+./
vidence of appropriate informed consent for procedures and treatments as quired by IC 16-34-2-1.1. State form 55920 (6-13) and 55321 (6-13)	V	1 1/2	V ₂	1 1/2	W	\ \sqrt{,}	1/	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1	\ \ \ \ \ \
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orders who treated or cared for the patient.	V/	1~_	Y		1	1.	/	" /-	1-7	1./
ondition on discharge, disposition of the patient, and time of discharge.	$+ \vee$		 ~	V	-V:/	\ \ \ /-	1-	1	+	+->
ischarge entry to include instructions to the patient or patient's legal		V	1	√	14	V	V	\ \ \	V	· V
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ony of any report filed with a state agency or law embreament agency.								·		
ursuant to a statutory reporting requirement. Vischange information to include:	+	1	 	+	1		1		, j	1
Signs and symptoms of possible complications	† / .	17		1	V	V	V	1	V	V/
Agrivities allowed and to be avoided	11	17	I V	IV.				TV_	1/	V,
Hygienic and other postdischarge procedures to be	V	1./	1			1		11	1	I V
followed		1 V.	+ 1/	+/-	+ - 7	+>	+ -	+ -	+ 7	1./
Clinic emergency phone numbers available on a twenty- four (24) hours basis	√	1 V.	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \] V,	V/	MA	\ \ /	1 4/	LVY	T_x_
four (24) nours basis Follow-up appointment, if indicated	17		LV	1 🗸		VI	IV	11	IV	V
Counseling regarding Rh typing	1 —].>		IV		1=		<u> </u>
Administration of Rh-impune globulin, if indicated -	1	1		ľ		. 15t)			l
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ABORTION CLINIC MEDICAL RECORD REVIEW

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test, a copy of a pregnancy test or an ultrasound Verification and documentation of gestational age	·/	1/1:	/:-	\ <u>\</u>	1	V	V,	V.	1	V.
Hematocrit or hemoglethin	V	V,c	V.	·V/	V	Vy.	1/	V/2	V	Vic
Rh typing Completion of the abortion documented by ultrasonography	14	V	V/	V	.V/	V/	1		. 4	1
or other clinical means	V	7)	V	1	ļ V	.¥	[•	1 1/≟	1 (7	
Provision of follow-up examination and services	V	V _	V	V		17	1321	y. 14.	F1711	1+1+1+1+
reanesthesia evaluation within forty-eight (48) hours before a surgical portion	X	, X	X	X.	X	X	X	X,	X	X
listory and physical examination report to include:		- :/-	×/	-	1	1	3/1	1	1	Va
Vital signs	-	XI	1/	17	1	V,	V	V	V	V
Allergies Any significant risk factors	Z	V	V,	Z	V	V/	V	· V/	V	V
The date written	1	1	1		1 1/	- V	1/2	1/7	1	1/2
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sults of any diagnostic studies	V	V	1/	1/	1-1/-	*/ <u>/</u>	1	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	14/	V
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rkers who treated or cared for the patient. Indition on discharge, disposition of the patient, and time of discharge.	+ -	1	Vi	V	1	LV.	V	1	1	V.
scharge entry to include instructions to the patient or patient's legal	1/	1	V	1	1./	V	1	. /		1
oresentative. The patient was referred to a hospital or other patient was referred to a hospital or other	 	ļ <u>.</u>	 	ļ	╁┷╌	1	 	 	<u> </u>	
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rsught to a statutory reporting requirement.	<u></u>		-		1		1		<u>ئ</u> ســــــــــــــــــــــــــــــــــــ	1
scharge information to include:	V.			1	17	1 7	 	. /-	1:2/	1
Signs and symptoms of possible complications Activities allowed and to be avoided	1	1			1	V	1 🗸			$\perp Z$
Hygienic and other postdischarge procedures to be				1	V	1	1			\ \(\)
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four (24) hours basis	V	1//	1/2		. I V	1 Y	.V	"	1 '	Į V.
Follow-up appointment, if indicated Counseling regarding-Rh typing	<u> </u>	.V	1	1			1	إنسيب [.] "	
Administration of Rh immune globulin; if indicated -	-	1			1]				
unless patient signs a waiver or other arrangements for						-				
administration are decumented Conscious sedation	1		1 :	1	1					
Prequent monitoring for verbal responses	X	X	🔀		×	X	×.	X	+×	+X $-$
Monitoring for respiratory, cardiovascular and neurological effects of the drugs being used.	X	X	\times	1X	\times	15	×	X	X	IX.
nstimesthetic evaluation for proper anesthesia recovery before discharge	X	X.	X	LX,	X	又	X	1	ĮX.	X
orn 56108 — Certification of Provision of Perinatal Floapice Information ime of Abortion Consent Decision)	X	X	X	X	×	X	X	X	X	X
rm 56113 - Certification of Provision of Perinatal Hospice Information	X	1X,	X,		· X	X	X	IX,	X	$\perp X$
orm 56114 - Disposition of Aborted Fetus	14/	<u>\</u> /~	1	+1/	+>/-	/-	1	$\pm \mathcal{F}$	+*/	+ \/
orm 56115 — Available Counseling after an Abortion	4 -	1 300	·I	<u> т.А.</u>	Charle	1. K	TANK MANAGER	À	-3 14	_1Y
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ABORTION CLINIC MEDICAL RECORD REVIEW

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includes:			initia National gali	· · · ;			, i-i, _			1 1	
On-site proof of pregnancy as evidenced by a pregnancy		1	1	1/		4			V.	$\sqrt{}$	-
test, a copy of a pregnancy test or an ultrusound Verification and documentation of gestational age	V/-	7	1/1		Y/	V / -	1/		/-	1	
Hematocrit or hemoglobin	1//	1//	V.	1	1/2	V	1	1/	1	1//	
- Rh typing	1 1/	V	()/	V,	1//	V		1/1.	- 1/	11	V
Completion of the abortion documented by ultrasonography	17	1/	v/	1	7	3/		J	1	· V	76)
or other clinical means	$\mathbf{Y}_{\mathcal{J}}$	*	,	1 ×	1 V	1 .6		À.	FIX	DW/VC	Met.
Provision of follow-up examination and services		, . , -		1		· · · · ·	F -4	خ ت ا	1231		
Preanesthesia evaluation within forty-eight (48) hours before a surgical abortion	X	X.	X	1	X		$\langle \mathcal{X} \rangle$	X	X	X	
History and physical examination report to include:	Fire. 32.	4 34.5				7			·		
Vital signs	Vip	Vy	W	V/A	V.	V/	. V.	V	1/2	V	
Allergies:	V _z	1	V	V/	V	·V	V	1	1/1	V/	
Any significant risk factors	12/2	1/	4	V	1	- V/-	V	- \ \ / \	1/1	1/	
The date written Appropriate medical history	1/2	37	17.71	1//	1	V	- V	4	13/	1/2	
Results of a physical examination	1	1/2		.//.	1/2	1/2	1/2	-X	W.	Va	
Résults of any diagnostic studies	VI	11	1/1	VY	11	1//	1/7	3//	VI	11/	
Results of any inboratory studies	V	J	V	V	V	1	Ų.	·V	V	V .	
Any allergies and abnormal drug reactions					<u> </u>					-	
Entries related to mesthesia administration	 	7									
Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1,1, State form 55320 (6-13) and 55321 (6-13).	V.	V/	1	*/ jr.	1.	V	17.	1	1	1	:
A report describing techniques, findings, and tissue removed or altered. Authentication of entries by the physician or physicians and health care		-V	V /	\ \rangle \rangle \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \ \rangle \rangle \ \rangle	- 2/-ye-		1/	V/	1/	- ¥_	
workers who treated or cared for the patient.	V.	V. j.	V	V.	V,	1	V	4%	V,	V	
Condition on discharge, disposition of the patient, and time of discharge.	11	V/	1/	17	W/	1.7	Vy	17.	<i>\infty</i> ,	VZ	
Discharge entry to include instructions to the patient or patient's legal		7		17	.7	1	1/	· 🗸	1		
representative. Copy of the transfer form, if the patient was referred to a hospital or other	<u>'</u>			,		<u> </u>		y			
facility.		<u> </u>	alien .		130		74	*	-/-	1	
Copy of the terminated pregnancy report. Copy of any report filed with a state agency or law enforcement agency.	T*	 25 ~	X	10-	*	 	_ <u></u>	7.	 V 	 	ĺ
purshant to a statutory reporting requirement.		******						H			
Discharge information to include:			1		- · · · · · · ·	· /:		1	1	1	l.
Signs and symptoms of possible complications	14/	1/	1/	17/	1//	1.1/	1/2	<u> </u>	- <u>`</u> /-	V/	<u> </u>
Activities allowed and to be avoided Hygienic and other postdischarge procedures to be	+-	LV.	1 1/	· ·/_	W/	1-1/	<u>//</u>	-V/	7 7	+	
Hygienic and omer positisenarge procedures to be	11.	v/	V,	w/	√.	\ \sqrt{\}	V	. V	V,	1 1/	1
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Follow-up appointment, if indicated		\[\frac{1}{2}\]	17/	W	l V	V	V.:	·V	MACE	SYOU	\00 <u>`</u>
Counseling regarding Rh typing	بسنسيه		V	-	1	1	<u></u>	بسب.		1	X400
Administration of Rh immune globulin, if indicated — unless patient signs a waiver or other arrangements for administration are documented									<u> </u>		
Conscious sedation		77.	1	1111			1. 1.]
Frequent monitoring for verbal-responses	X	×	X	X	1		X	X	<u>LX</u>	X	
Monitoring for respiratory, cardiovascular and	X	X	X		13/	~	- X	X	l X	1 X	1
neurological effects of the drugs being used.			10		2	 		1	 ⟨〉	1 /x -	1
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Form 55:08 — Certification of Provision of Permana raespice information (Time of Abortion Consent Decision)	X	X	X	X		X	ベ	Χ.	X	12	
Form 56113 - Certification of Provision of Perinatal Hospice Information	IX	X.				ح			je	1 ,/	1
Form 56114 - Disposition of Aborted Petus	1		V	1		1/	1/2	14	1.1/	1/	(N)
Form 56115 - Available Counseling after an Abortion	1 100	<u> </u>	1_/_	مرا ا	14.	1 1/	<u> </u>	L V	1. V.	1 V	$\mathcal{N}_{\mathcal{L}}$
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Facility Name	Planne	d Parenthood - Me	rrillville	Surveyor Name	Tammy Berber, RN
Provider Number		Survey	or Number	35731	Discipline PHNS
Observation Dates:	From	3-19-2018	To _	3-21-2018	
					
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Facility Name	Planned Parenthood - Merrillville	Surveyor Name	Tammy Berber, RN
Provider Number	Surveyor Number	35731	Discipline PHNS
Observation Dates:	From 3-19-2018 To	3-21-2018	(2)
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Facility Name	Planned	l Parenthood - Mei	rrillville	Surveyor Name	Tammy	Berber, F	N
Provider Number		Surveyo	or Number	35731	Discipline		(3)
Observation Dates:	From	3-19-2018	To	3-21-2018			(3)
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Facility Name	Planned	Parenthood - Merrill	lville	Surveyor Name	Tammy Berber, KN	
Provider Number		Surveyor N	lumber	35731	Discipline PHNS	-
Observation Dates:	From	3-19-2018	To	3-21-2018		(4")
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Facility Name	Planne	i Parenthood - Merri	llville	Surveyor Name	Tammy	Berber, RN
Provider Number		Surveyor	Number	35731	Discipline	PHNS
Observation Dates:	From	3-19-2018	To _	3-21-2018	-	(5
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Facility Name	Planne	d Parenthood - Merrilly	ville	Surveyor Name	Tammy	Berber, RN
Provider Number		Surveyor No	umber	35731	Discipline	PHNS
Observation Dates:	From	3-19-2018	To	3-21-2018	•	(6)
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Facility Name	Planned Parenthood - Merrillville			Surveyor Name	Tammy Berber, RN		
Provider Number			or Number	35731	Discipline PHNS		
Observation Dates:	From	3-19-2018	To _	3-21-2018	· •		
TAG/CONCERNS				OCUMENTATION		***************************************	
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Facility Name	Planned	l Parenthood - Merr	illville	Surveyor Name	Tammy	Berber, RN
Provider Number		Surveyor	Number	35731	Discipline	PHNS
Observation Dates:	From	3-19-2018	To _	3-21-2018		(8)
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Facility Name	Planned Parenthood - Merrillville Surveyor Name Tammy Berber, RN
Provider Number	Surveyor Number 35731 Discipline PHNS
Observation Dates:	From 3-19-2018 To 3-21-2018
	DOCUMENTACION
TAG/CONCERNS	DOCUMENTATION
3-11-18	Exit & Grace,
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7 5	是自	4	C 19	7	Tag#	Planner Respon Survey Revised
1.72 Medical director falled to examine the credentials of a candidate for reappointment to the medical staff, annual physician review signed by physician other than medical director	to assure medical records are provide safeguards for assure medical records are protected from fire, water, and other sources of damage	96 CA Program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to all services, including those furnished by a contractor; currently lacking anarmacy and contracted occupational health (NONe)	90 Facility failed to have policies in place for impaired Inself to care workers, criminal history, and disciplinary ection	To coverning body failed to review trass program for 2 of 3 facility-provided services and 2 of 9 contracted services (faulidry, pharmacy, and contracted occupational health)	Problem Identified	Planned Parenthood of Indiana and Kentucky, Merriliville Eacility #160111161. Response to ISDH Abortion Licensing Review conducted January 31, 2017. Survey results received February 17, 2017. Revised \$/6/2017 post conversation with J. Hembree on 3/2/2017.
Madical bylaws will be developed to include medical director review of candidate credentials, provider reviews, and appointment and reappointment of providers Providers Replay and sign annual review of physician, will review credentials and competency at that time	Medical policy updated to include that medical records must be protected from fire, water, and other sources of damage	Quality measures to be developed to address pharmacy and contracted health services; these are to be included in the Report of Management Operations and reviewed by the Board of Directors and Quality Management and Infection Prevention Committee on quarterly basis; all measures to be summerized in written plan for clarity	Human Resources to create policies to address impaired freatth care workers, criminal history, and disciplinary action	Report of Management Operations format to be updated to include faundry, pharmacy, and contracted occupational health services for clarity of board review; quality measures to be developed on these items	Corrective Action	a Facility #160111160: invary 31, 2017 1/2/2017
Vice President of Patient Services, Medical Director, and Risk and Quality Manager	Risk and Quality Manager	Risk and Quality Manager	Director of Human Resources	Risk and Quality Manager	Responsibility	
3/37/2017	3/2/2017	3/31/2017	3/31/2017	3/31/2017	Correction	
Bylaws written, approved by legal, to be accepted at February. Board meeting	Completed (Risk and Quality Manual drafted	Completed Value (1/2)	Completed Course py Course py Course py Course py Co	Notes	

Electrical current, leakage checks not performed on equipment	reporting adverse reactions and medication errors to the physician responsible for the patient
418 Electrical current, leakage checks not performed Current &PINX preventive maintenance vendor (K&R) on equipment contract updated to include electrical current leakage checks on all applicable equipment to be completed annual with medical equipment inspections	The life
Facilities Coordinator	Vice President of Patient Services, Phatient Services, Medical Director, and Risk and Quality Manager
Next annual K&R inspection scheduled march 2017, electrical current leakage checks to be performed at that time	3/31/2017
Pending	Bylaws written, approved by legal, to be accepted at February poard meeting

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PLANNED PARENTHOOD OF INDIANA AND KENTUCKY 8590 GEORGETOWN ROAD INDIANAPOLIS, INDIANA

) Old Chick of well in the control of the control o		1 ' '	(X2) MULTIPLE CONSTRUCTION								
AND PLAN C	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	•	COMI						
		011118	B, WING		03	/29/2018					
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
PLANNED	PARENTHOOD OF INDI	ANA AND KENTUCK	ORGETOWN RD POLIS, IN 46268								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE					
. T 000	INITIAL COMMENTS		T 000								
	This visit was for a st	ate licensure survey.	-		•						
	Facility Number: 011	118									
	Survey Date: 03-27-2	2018 to 03-28-2018									
	QA: 4/02/2018	•	1								
T 004	410 IAC 26-2-7 LICE	NSE REQUIREMENTS	Т 004								
	410 IAC 26-2-7				•	***************************************					
	A license issued unde conspicuously posted open to patients.	er this article must be I on the premises in an area									
						a water than the same of the s					
The state of the s	This RULE is not me Based on observation conspicuously post a	ot as evidenced by: n, the facility failed to current license for 1 facility.									
,	Findings Include:				•						
	employee #A2, Vice Services, and employ Manager, it was obse	yee #A5, Health Center erved in the waiting room current license posted. The bserved to have an									
Indiana State	Department of Health DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE .		(X6) DATE					

	tate Department of He		Total LI II TIDI C	CONSTRUCTION	(X3) DATE SU	RVEY				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ` '		COMPLETED					
AND PLAN C	PLAN OF CORRECTION									
						1				
		011118	B. WING		03/29	9/2018				
		OWDER TAX	SECTION OF STATE OF S	TE ZIO CODE						
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
DIAMNED	PARENTHOOD OF INDI	ANA AND KENTUCE	ORGETOWN RD	9						
LEGITAL	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	INDIANA	POLIS, IN 46268							
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE				
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP.	RIATE	DATE				
TAG	KEGGERIORI OK	CO (DECENT TRANSPORTED TO A STATE OF THE STA		DEFICIENCY)						
			7.404							
T 134	Continued From page	1	T 134		Ì					
T 134	410 IAC 26-7-2 MED	ICAL RECORDS	T 134							
דטון	4 10 100 20-1-2 MEDI	707 12 (120 2112 2								
	410 IAC 26-7-2(c)									
	4101/102012(0)									
	(c) Patient records for	r surgical abortions must								
	document and contain	n, at a minimum, the			ĺ					
· ,	following:	,				l				
	(1) Patient identific	cation.								
	(2) Appropriate me	edical history.								
	(3) Results of the	following:				i				
	(A) A physical (examination.	1							
	(B) Diagnostic	or laboratory studies, or both								
	(if performed).									
		ınd abnormal drug reactions.								
	(5) Entries related	to anesthesia								
	administration.									
	(6) Evidence of ap	propriate informed consent		***************************************						
	for procedures and tr	eatments as required by IC		,	}					
	16-34-2-									
	1.1.	n to a to a to a to a to a to a to a to								
	(7) A report descri	ibling techniques, findings,								
	and tissue removed o	of ontrion by the abyeidian								
	(8) Authentication	of entries by the physician alth care workers who			•					
	treated or	ann baid wontors who								
	treated or cared for the patie	ent.]							
	(a) Condition on d	lischarge, disposition of the								
	patient, and time of d									
	(10) Dischame en	try to Include Instructions to								
	the patient or patient	's legal representative.								
	(11) A copy of the	following:								
	(A) The transfe	er form if the patient was								
	referred to a hospital	or other facility.								
	(B) The termin	ated pregnancy report filed								
	with the department.									
İ	(12) Any report file	ed with a state agency or law		1						
	enforcement agency	pursuant to a statutory								
_	reporting									
	requirement.									
I .	1					ł <u>.</u>				

Indiana State Department of Health			WOLLSTON F	CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		COMPLETED	
WUN SINU	N OOMICOTORY	, , , , , , , , , , , , , , , , , , ,	A. BUILDING:			
			B. WING	•	03/29/2018	
		011118	I = 1		1 00/20/2010	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
Di Abibi≓h	PARENTHOOD OF INDI	ANTA AND MENTION	RGETOWN RD			
PLANNED		пин	OLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D SE COMPLETE	
				pp (out to 1)		
T 134	Continued From page	2	T 134			
	, -					
			1			
	This RULE is not me	t as evidenced by:	A STATE OF THE STA			
	Based on document	review and interview, one (1)				
	or thirty (30) medical	records reviewed lacked propriate informed consent		·		
	for procedures and fr	eatments as required by IC				
	16-34-2-1.1.	• •				
					<u> </u> -	
	1. PPINK Administra	tive Chapter 4: Consent,				
	Informed Consent an	d Patient Education, last ated: The informed consent				
	process must take pla	ace. It is the professional				
	and legal duty of eve	ry affiliate to provide each				
	patient with adequate	Information regarding the				
	nature of the propose	ed services.				
	2 Medical record #3	O lacked documentation of a				
	signed abortion inform	med consent certification,				
	State Form 55320.					
	A 01 W	d Indicated in Interview on				
	3. Statt member #04	4 indicated in interview on ours, that the medical record			L	
	#30 lacked documen	tation of the required form.				
Į	He/she also Indicated	d that since the forms are				
	scanned into the EM	R, that it may not have				
	gotten scanned in.				ŧ.	
		DONNEL DOLLOIED AND	T 144			
T 144		SONNEL POLICIES AND	1 1-7-7			
	RECORDS					
	410 IAC 26-8-1(c)(1)	`				
	(c) The clinic must de	o the following:		1		
	(1) Maintain curre	nt job descriptions with				
	f *	illes for all personnel and				
	annual	uations, based on the job			-	
	performance eval	מלוסוום! המסמת פנו נווס לסם				

Indiana S	tate Department of He	alth				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Man Francis		A. BUILDING: _	and the state of t			
		011118	B. WNG		.03/29/2018	
			DRESS, CITY, STA	TE ZIR CODE		
	ROVIDER OR SUPPLIER	8590 GEC	RGETOWN RD	This sale Court		
PLANNED	PARENTHOOD OF INDI	ANA AND KENTICE	OLIS, IN 46268	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
T 144	Continued From page	3	T 144	4		
		employee and contract and				
	personnel.					
		•		•		
•						
	This RULE is not met as evidenced by: Based on document review and interview, the facility falled to follow its policy to conduct an annual evaluation on 1 of 4 employees files					
	reviewed.					
	Findings include:					
	Review of the Emp February 2015, Indica an annual performance	oloyee Handbook, approved ated employees may receive ce evaluation.				
	Review of 4 emploindicated file P4, Nurseany documentation of evaluation.	se Practitioner, did not have		·		
·	employee #A2, Vice i confirmed all the abo policy was as indicate	her documentation was				
T 168	410 IAC 26-8-3 PERS	SONNEL POLICIES AND	T 168		,	
-	410 IAC 26-8-3(b)					
	r		r			

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1			(X3) DATE SURVEY COMPLETED	
	011118	B. WNG	B. WING		29/2018	
ROVIDER OR SUPPLIER						
PARENTHOOD OF INDI	ANA AND KENTICE			· · · · · · · · · · · · · · · · · · ·	ş · · · · · · · · · · · · · · · · · · ·	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
(b) The clinic shall en resuscitation (CPR) o with current standard for all health care wor agency personnel when the control of the control	sure cardiopulmonary ompetence in accordance s of practice and clinic policy kers including contract and o provide direct patient care. It as evidenced by: eview and interview, the that one (1) staff members	T 168				
reviewed and 1 of 6 nreviewed, had docum resuscitation (CPR) of policy. Findings include; 1. Review of a facility 0417, CPR Certification 4/21/2017, indicated Purpose: All staff participating in Life Support (BLS) Conception Resuscitation certified Association. Policy: All staff who are not comparison care. 2. Nursing Personne assistant, who was his	nedical staff credential files ented cardiopulmonary ompetency per facility y document titled PPINK on Policy, approved the Following; In patient care must be Basic ardiopulmonary to by the American Heart CPR certified at hire are tification prior to beginning I #N3's file, healthcare are 19/5/2017, and does					
patient care, lacked of training.	locumentation of CPR	·				
	CONTINUED OF INDI- SUMMARY STO (EACH DEFICIENCY REGULATORY OR I COntinued From page (b) The clinic shall en resuscitation (CPR) of with current standards for all health care wor agency personnel wh This RULE is not me Based on document relinic failed to ensure of ten (10) staff member reviewed and 1 of 6 n reviewed, had docum resuscitation (CPR) of policy. Findings include; 1. Review of a facility 0417, CPR Certification 4/21/2017, indicated in 947/2017, indicated in 948/2017, CONTINUED OF INDIANA AND KENTUCH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the clinic failed to ensure that one (1) staff members of ten (10) staff member's personnel files reviewed, had documented cardiopulmonary resuscitation (CPR) competency per facility policy. Findings include; 1. Review of a facility document titled PPINK 0417, CPR Certification Policy, approved 4/21/2017, indicated the Following; Purpose: All staff participating in patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation certified by the American Heart Association. Policy: All staff who are not CPR certified at hire are required to obtain certification prior to beginning patient care. 2. Nursing Personnel #N3's file, healthcare assistant, who was hired 9/5/2017, and does patient care, lacked documentation of CPR	This RULE is not met as evidenced by: Based on document eview and interview, the clinic failed to ensure that one (1) staff members of ten (10) staff member's personnel files reviewed, had documented cardiopulmonary resuscitation (CPR) competency per facility policy. Findings include; 1. Review of a facility document titled PPINK 0417, CPR Certification Policy, approved 4/2/12017, indicated the Policwing; Purpose: A. BUILDING: 0.011118 STREET ADDRESS, CITY, STA 8890 GEORGETOWN RD INDIANAPOLIS, IN 46281 ID INDIANAPOLIS, IN 46281 ID INDIANAPOLIS, IN 46281 ID PREFIX TAG Tontinued From page 4 (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the clinic failed to ensure that one (1) staff members of ten (10) staff member's personnel files reviewed, had documented cardiopulmonary resuscitation (CPR) competency per facility policy. Findings include; 1. Review of a facility document titled PPINK 0417, CPR Certification Policy, approved 4/2/12017, indicated the Pollowing; Purpose: All staff participating in patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation certified by the American Heart Association. Policy: All staff who are not CPR certified at hire are required to obtain certification prior to beginning patient care. 2. Nursing Personnel #N3's file, healthcare assistant, who was hired 9/5/2017, and does patient care, lacked documentation of CPR	CAT PROVIDERSUPPLER CAT PROVIDERSUPPLER CAT COMPRESSION CAT PROVIDERS UPPLIER COMPRESSION COMP			

Indlana S	Indiana State Department of Health								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _						
			B. WING		03/29/2018				
		011118	D. 1444G		1 03/28/2016	'			
NAME OF PE	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	re, ZIP CODE					
PLANNED	PARENTHOOD OF INDI	ANA AND KENTIICE	EORGETOWN RD APOLIS, IN 46268						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		6) PLETE TE			
T 168	Continued From page	1.5	T 168		•				
	3. Review of medical staff credential files indicated file MD#6 Medical Director, a direct patient care provider, did not have any documentation of current CPR competency, per facility policy. 4. In interview on 3/28/2018 at 1050 hours, employee #A7, Human Resources Generalist, confirmed all the above and no other documentation was provided prior to exit. 5. In Interview on 3/28/2018 at 1200 hours, staff member #O5, Human Resources, indicated agreement with the finding that staff #N3's personnel file lacked documentation of CPR training.								
				•					
				·					
Т 206	410 IAC 26-11-1 INFI PROGRAM	ECTION CONTROL	T 206						
	410 IAC 26-11-1(a)(1)			POWER TO A CONTRACT OF THE CON				
	(a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients.								
	interview, the facility	n, document review and falled to provide a safe and t that minimizes infection							
	i umunga muuud.								

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 03/29/2018 B. WNG 011118 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8590 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KENTUC! INDIANAPOLIS, IN 46268 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 206 T 206 Continued From page 6 1. On 03-27-2018 at 3:25 pm in the presence of employee #A2, Vice President of Patient Services, employee #A5, Health Center Manager, and employee #A6, Health Care Assistant, it was observed in an ultrasound room there were test strips being used to determine the effectiveness of Cidex, a chemical agent being used to disinfect probes for ultrasound procedures. 2. Review of the manufacturer's recommendation on the insert package of instructions for Quality Control Procedures of the test strip bottle indicated testing of positive and negative controls must be performed on each newly opened bottle of CIDEX OPA Solution. On the above date and time, employee #A6 was requested to provide documentation of following the above-stated Quality Control Procedures. The employee indicated there was no such documentation because the Quality Control Procedures were not performed, and no other documentation was provided prior to exit. T 320 410 IAC 26-16-1 PHARMACEUTICAL T 320 SERVICES 410 [AC 26-16-1(2) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (2) Records of stock supplies of all scheduled substances, including an accounting for all Items purchased and dispensed.

STATEMENT	ndiana State Department of Health TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
•	011118		B. WING		03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	FE, ZIP CODE		
PLANNED	PARENTHOOD OF INDI	ANA AND VENTICE	RGETOWN RD OLIS, IN 46268			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETE	
T 320	Continued From page	7	T 320			
	facility failed to follow scheduled substance:	eview and interview, the its policy for accounting of s in 67 of 90 instances, and a Medical Director Review of		·		
	Findings include:					
·	Review of facility policy titled Health Center Logs, REFERENCE CODE: PS04, approved 11-29-2017 indicated staff must follow the instructions on each log.					
	2. Review of 9 facility CONTROL SUBSTAN through 3/4/18, indica	ICE LOG, dated 1/31/18		,		
	day by 2 staff member members, 1 licensed center manager or as control substances. may only complete the member, Health Cent Manager is not on sit Center Manager shou	completed every procedure are (2 licensed staff staff member and the health esistant manager) for all An unlicensed staff member se count if a licensed staff ter Manager, or Assistant e. Provider and Health ald review log monthly and signing and dating below.				
	3. Further review of titled CONTROL SU	the 9 facility documents BSTANCE LOG indicated:				
	staff members and 6	signed indicating the		·		

Indiana State Department of Health							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	-			
•			B. WNG	,	03/29/2018		
		011118	D. WING		1 03/28/2010		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
DI AMBITTO	PARENTHOOD OF INDI	ANA AND KENTIICI	EORGETOWN RD				
PLANNED	PARENTAGOD OF HADI	INDIAN	APOLIS, IN 46268				
(X4) ID	SUMMARY ST/	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N (X5) BE COMPLETE		
PREFIX TAG	REGULATORY OR L	SC (DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE		
				DETOLION			
T 320	Continued From page	8	T 320				
	4. In interview on 03-	27-2018 at 2:35 pm,					
	employee #A2, Vice I	President of Patlent	1				
,	Services, confirmed a	Ill the above and no other					
	documentation was p	rovided by exit.					
T 404	440 140 00 47 0 00 10	m	T 404				
1 404	410 IAC 26-17-3 PHY PLANT,MAINT.,EQUI		1 70				
	L FULL MULITATIVE SOL	a quitti ajorn di t					
	410 IAC 26-17-3(2)		•				
	The condition of the	physical plant and the nent must be developed and			:		
	maintained in such a	manner that the safety and					
	well-being of patients	is assured as follows:		·			
	(2) No condition ma	ay be created or maintained					
	that may result in a h	azard to:					
	(A) patients; (B) authorized	visitors, or					
	(C) employees.						
	, , ,	•					
				LL VOYAGE PROPERTY OF THE PROP			
	This RULE is not me	t as evidenced by:					
	Based on observation	n, the facility created					
	condition that may ha	ive resulted in a hazard to	(
	patients, authorized v	visitors, or employees.					
	Findings include:			,			
	I RIGINGS HONGS				Tangent of the same of the sam		
, '	1. On 03-27-2018 at	3:15 pm in the presence of					
-	employee #A2, Vice	President of Patient					
,	Services, and employ	yee #A5, Health Center erved in the hallway next to a					
	crash cart, there was	1 small oxygen tank	***************************************				
	unsecured by chain o	or holder. If the tank was					
	knocked over and bro	oke the head off the					
	compressed cylinder	, it could result in harm to					

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PRINTED: 05/24/2018 FORM APPROVED

Indiana State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			•			
		011118	B, WING		03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		ANA AND CENTICE	RGETOWN RD			
PLANNED	PARENTHOOD OF INDI	INVIANAI	OLIS, IN 4626			
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION . (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR L	SC DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IIATE DATE	
ALL						
T 404	Continued From page	9	T 404	**************************************	}	
	people and/or propert	y.				
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				Service Servic		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		011118	B. WING		03/29/2018	
	PROVIDER OR SUPPLIER D PARENTHOOD OF	INDIANA AND KE 8590 GE	DDRESS, CITY, S' ORGETOWN F POLIS, IN 462	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Т 000	INITIAL COMMENT	rs	T 000			
1	This visit was for a	state licensure survey.				
	Facility Number: 0	11118				
	Survey Date: 03-2	7-2018 to 03-28-2018				
	QA: 4/02/2018					<u> </u>
T 004	410 IAC 26-2-7 LIC	ENSE REQUIREMENTS	T 004			
\$ 	410 IAC 26-2-7					1
! {		der this article must be ed on the premises in an area				
!						
	**					
			}			1
	Based on observati	net as evidenced by: ion, the facility failed to a current license for 1 facility.				- Andread Andread - Andread - Andread - Andread - Andread - Andread - Andread - Andread - Andread - Andread -
} 	Findings include:					
***************************************	employee #A2, Vice Services, and empl Manager, it was ob- area there was not	at 2:50 pm. in the presence of a President of Patient oyee #A5, Health-Center served in the walting room a current license posted. The				• • • • • • • • • • • • • • • • • • • •
To the state of th	license posted was expiration date of 0	observed to have an				
ana State	Department of Health DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	MATURE	TITLE	<u> </u>	1

STATE FORM

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TITLE

(X6) DATE

' 🗦 Indiana	State Department of	Health			. 011111	7
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION		SURVEY PLETED
		011118	B. WING		03/:	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLANNI	D PARENTHOOD OF	ΙΝΠΙΔΝΔ ΔΝΒ ΚΕ	ORGETOWN I POLIS, IN 46:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEPICIENCY)	ULD BE	(X5) COMPLETE DATE
T 134	Continued From pa	age 1	T 134	-		
T 134	410 IAC 26-7-2 ME	DICAL RECORDS	T 134			
	410 fAC 26-7-2(c)					
		for surgical abortions must				;
	document and con	tain, at a minimum, the				
	following: (1) Patient ident	dification.				
	(2) Appropriate (3) Results of the	medical history. se following:				
	(A) A physica	al examination.				
	(if performed).	ic or laboratory studies, or both				
		s and abnormal drug reactions. ed to anesthesia				,
	administration.					
	for procedures and 16-34-2-	appropriate informed consent I treatments as required by IC				
	1.1. (7) A report des	cribing techniques, findings,				
	and tissue remove	d or altered.				
	or physicians and i	on of entries by the physician nealth care workers who				
1	cared for the pa	itient. n discharge, disposition of the	-			
	patient, and time o	f discharge.				
	(10) Discharge the patient or patie	entry to include instructions to nt's legal representative.				
	(11) A copy of the	ne following: sfer form if the patient was				
	referred to a hospi	tal or other facility.		•		:
	with the departmen	ninated pregnancy-report filed nt.				
	(12) Any report	filed with a state agency or law cy pursuant to a statutory	-			
	reporting	al kanamana sa mamana.				
	requirement.					

indiana S	State Department of	Health				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN	OF CORRECTION	IDEN; IFICATION NONIBER.	A. BUILDING:			
			B. WING		02/2	9/2018
		011118	D. 111145		USIZ	312010
NAME OF F	ROVIDER OR SUPPLIER			STAFE, ZIP CODE		
PLANNE	D PARENTHOOD OF	INDIANA AND KE	RGETOWN			
		HADIWAN	OLIS, IN 46	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
T 134	Continued From pa	age 2	_T 134			
T 144	Based on document of thirty (30) medic documentation of a for procedures and 16-34-2-1.1. 1. PPINK Administ Informed Consent revised 6/2016, incorposes must take and legal duty of expatient with adequanture of the proposes. 2. Medical record signed abortion informed State Form 55320. 3. Staff member # 3/28/2018 at 1000 #30 lacked document in the Exportance in the Exp	#30 lacked documentation of a formed consent certification, O4 indicated in interview on hours, that the medical record entation of the required form. Ited that since the forms are IMR, that it may not have	T 144			
	(c) The clinic must (1) Maintain cu					
		valuations, based on the job				

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ 011118 03/29/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8590 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KE INDIANAPOLIS, IN 46268 (X6) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) T 144 T 144 Continued From page 3 description, for each employee and contract and personnel. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy to conduct an annual evaluation on 1 of 4 employees files reviewed. Findings include: 1. Review of the Employee Handbook, approved February 2015, indicated employees may receive an annual performance evaluation. 2. Review of 4 employee personnel files indicated file P4, Nurse Practitioner, did not have any documentation of a current annual evaluation. 3. In interview on 03-28-2018 at 10:30 am, employee #A2, Vice President Patient Services, confirmed all the above, including the facility policy was as indicated in the Employee Handbook, and no other documentation was provided prior to exit. T 168 410 TAC 26-8-3 PERSONNEL POLICIES AND T 168 RECORDS 410 IAC 26-8-3(b)

Indiana State Department of Health

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MIDICAN	0, 00,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		A BUILDING:			-
	_	011118	-8: WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		8590 GEO	RGETOWN			
PLANNE	D PARENTHOOD OF	INDIANA AND RE INDIANAF	OLIS, IN 46			
(X4) ID PREFIX TAG	-{EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
T 168	Continued From pa	age 4	T 168			
, 100	(b) The clinic shall	ensure cardiopulmonary) competence in accordance				
	with-current standa	rds of practice and clinic policy				į
	tor all nealth care v	vorkers including contract and who provide direct patient care.		•		
		. ,				
				_		
	This RULE is not i	met as evidenced by:				
	Based on documer	nt review and interview, the				
	of ten (10) staff me	re that one (1) staff members ember's personnel files				
	reviewed and 1 of	6 medical staff credential files				
	reviewed, had doci resuscitation (CPR policy.	umented cardiopulmonary c) competency per facility	:			
	Findings include;		j			
	0417, CPR Certific	ility document titled PPINK ation Policy, approved				
	4/21/2017, indicate Purpose:	ed the Following;				_
	All staff participating	ig in patient care must be Basic				
:		Cardiopulmonary fied by the American Heart				:
	Association.					
_		ot CPR certified at hire are certification prior to beginning				
	assistant, who was	nel #N3's file, healthcare s hired 9/5/2017, and dees d documentation of CPR	-			
			1			:

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STATEMEN	Indiana State Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011118	B. WING		03/	29/2018
	PROVIDER OR SUPPLIER D PARENTHOOD OF	INDIANA AND KE 8590 GE	ODRESS, CITY, S ORGETOWN F APOLIS, IN 46:	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5)_ COMPLETE DATE
T 168	Continued From-pa	age-5	T 168			
	indicated file MD#6 patient care provide documentation of of facility policy. 4. In interview on 3 employee #A7, Hur confirmed all the al documentation was 5. In interview on 3 member #O5, Hum	s provided prior to exit. 3/28/2018 at 1200 hours, staff nan Resources, indicated				
T 206	personnel file lacke training.	e finding that staff #N3's ed documentation of CPR IFECTION CONTROL	T 206			
	410 IAC 26-11-1(a))(1)	-			
	that-minimizes infe following: (A) Patients. (B) Health ca	afe and healthful environment ction exposure and risk to the		·		
-	Based on observatinterview, the facili	met as evidenced by: tion, document review and ty failed to provide a safe and ent that minimizes infection in 1 instance.				

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION. STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 03/29/2018 011118 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8590 GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KE INDIANAPOLIS, IN 46268 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH-CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 206 T 206 Continued From page 6 1. On 03-27-2018 at 3:25 pm in the presence of employee #A2, Vice President of Patient Services, employee #A5, Health Center Manager, and employee #A6, Health Care Assistant, it was observed in an ultrasound room there were test strips being used to determine the effectiveness of Cidex, a chemical agent being used to disinfect probes for ultrasound procedures. 2. Review of the manufacturer's recommendation on the insert package of instructions for Quality Control Procedures of the test strip bottle indicated testing of positive and negative controls must be performed on each newly opened bottle of CIDEX OPA Solution. 3. On the above date and time, employee #A6 was requested to provide documentation of following the above-stated Quality Control Procedures. The employee indicated there was no such documentation because the Quality Control Procedures were not performed, and no other documentation was provided prior to exit. T320 410 IAC 26-16-1 PHARMACEUTICAL T 320 **SERVICES** 410 IAC 26-16-1(2) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.

Indiana State Department of Health STATE FORM

Indiana State Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 03/29/2018 011118 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8590-GEORGETOWN RD PLANNED PARENTHOOD OF INDIANA AND KE INDIANAPOLIS, IN 46268 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH-DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 320 T.320 Continued From page 7 This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy for accounting of scheduled substances in 67 of 90 instances, and failed to document the Medical Director Review of the log used for the accounting in 9 of 9 instances. Findings include: 1. Review of facility policy titled Health Center Logs, REFERENCE CODE: PS04, approved 11-29-2017 indicated staff must follow the instructions on each log. 2. Review of 9 facility documents titled CONTROL SUBSTANCE LOG, dated 1/31/18 through 3/4/18, indicated the following: Instructions: Must be completed every procedure day by 2 staff members (2 licensed staff members, 1 licensed staff member and the health center manager or assistant manager) for all control substances. An unlicensed staff member may only complete the count if a licensed staff member. Health Center Manager, or Assistant Manager is not on site. Provider and Health Center Manager should review log monthly and document review by signing and dating below. 3. Further review of the 9 facility documents titled CONTROL SUBSTANCE LOG indicated: 90 daily entries - 23 were initialed by 2 licensed. staff members and 67 were initialed by only 1 licensed staff member 9 log pages were not signed indicating the Provider had reviewed.

Indiana (Indiana State Department of Health							
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T 404	410 IAC 26-17-3 PI PLANT,MAINT.,EQ	HYS. NUIP.,ENVIR.,SAFETY	T 404					
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	overall clinic environmaintained in such well-being of patien	d visitors; or				·		
7 77 77 1	Based on observati condition that may t patients, authorized	net as evidenced by: on, the facility created I nave resulted in a hazard to I visitórs, or employees.						
ļ	Findings include:				i			
	employee #A2, Vice Services, and employed Manager, it was observath cart, there was unsecured by chain knocked over and b	at 3:15 pm in the presence of a President of Patient oyee #A5, Health Center served in the hallway next to a served in the hallway next to a served in the tank was or holder. If the tank was proke the head off the er, it could result in harm to		-				

PRINTED: 05/30/2018 FORM APPROVED

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Facility Name Planned Parenshood - Inde/s
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ABORTION CLINC
DOCUMENT REQUEST - ADMINISTRATION (pg. 1 of 4)
All documents and records need only be since last licensure survey. If any documents are in a binder or folder, please tag the appropriate ones using the numbers next to each requested item.
Governing Body
70018 - Minutes of governing body (if applicable)
1 8020 - Documentation of Clinic Administrator appointed (if needed), by governing body
2026 - Review, at least every 6 months, reports of management operations by gov body
6028 - Ownership—copy of articles of incorporation
0030 - Approval of appointments to or contracts with medical staff
0034 - Triennial review of policies and procedures (P&P)
10036 - P&P for communication with physicians concerning patient emergency
ne. reporting licensed health professionals relative to not meeting licensure requirements b. documenting actions against licensed health professionals who fail to comply with clinic P&P
reporting information required by statute to report to state or law enforcement
agency 0040 - Constitution and bylaws of governing body (if applicable) - 40frov. 11-29-2017
1/42 - Designation of medical director and documentation of liaison
★044 - Clinic administrator
Ma. designation of day-to-day responsibilities and authority (job description)
*b. criteria as to educational and experience requirements
★c. In writing, written responsibility and authority
10046 - Attendance of clinic administrator at board meetings and representative
medical staff meetings, if applicable
6048 - Designation of who's in charge in administrator's absence and participate in
development and implementation of policies
10050 - Documentation physicians contracted or appointed to provide medical services
20054 - If more than 1 physician, documentation of:
medical director coordinator of medical staff
6. current medical staff roster 6. Current medical staff roster 6. Current medical staff acted upon advice and recommendation of medical
N Company of the Comp
director \$\int_0058 -Examine credentials for physician appointment, reappointment, contract to medical staff
10038 -Examine credentials for physician appointment, responsition, training, experience, judgment
★0062 - Documentation as per ABORTION CLINIC DOCUMENT REQUEST - CREDENTIAL FILE REVIEW
Credential File Review
#0066 - Documentation med staff accountable to gov body for quality of care provided
20068 - Documentation procedures performed only by physician approved by governing body to perform such
procedures and the procedures are the procedures and the procedures are the procedures and the procedures are the procedures and the procedures are the procedure are
10070 - Documentation governing body ensures procedures limited to those authorized
20072 - Documentation a licensed medical staff physician responsible for care and
treatment of clinic patients
treatment of clinic patients Ly (A) 3-27 930 4-leviewed 3-28

Facility Name Sanned Parenthood - Indpls
Surveyor fach Collem Date 3-27-2018
ABORTION CLINC DOCUMENT REQUEST - ADMINISTRATION (pg. 2 of 4)
All documents and records need only be since last licensure survey. If any documents are in a binder or folder, please tag the appropriate ones using the numbers next to each requested item.
0074 - Documentation contractors for medical services furnish them in such a manner to permit clinic to comply with all applicable statutes and rules 0076 - Quality assurance program includes all services provided by contractors 0078 - List of contracts with scope and nature of services - hot out 1344 - 500 his
Administration 0080 - Qualified person to be administrator 0084 - Implementation of internal and external disaster emergency preparedness plans and documentation of outcomes
and documentation of outcomes 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of outcomes 1086 - Documentation of: 1088 - P&P for immediate lifesaving measures, including timely assessment, basic life support, appropriate transfer 1088 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - Documentation of: 1086 - D
20092 - Policy to address internal review of unusual occurrence and disasters, including patient injuries or marked deterioration of patient condition occurring under unanticipated or unexpected circumstances, unexplained loss of or theft of a controlled substance, and deaths occurring within the clinic
Quality Assessment (QA) and Improvement 20094, 0096, 0098, 0100, 0102, 0103, 0104, 00105 – See ABORTION CLINIC - DOCUMENT REQUEST QA/PI MONITORS
Medical Records ### Medical Records ### Medical Records ### Medical Records ### Medical Records #### Medical Records #### Analysis of the Computation of Care and Services provided ### Analysis of Care and Services provided #### Medical Records ###################################
110 - Policies for safeguarding records from fire, water, other sources of damage 112 - Maintenance of records for appropriate time frame 10116 - If unit record system not used, policy describing system to retrieve all divergently located record components 10120 - Medical records retained in original or legally reproduced form
 №P for use of plain paper fax 124 - Documentation of system of coding and indexing to retrieve records 10126 - P&P for: Xa. release of information
W. ensuring unauthorized individuals cannot gain access to medical records 19128 - register of all patients treated to include, identification data, treatment treated, attending physician, condition on discharge, transferred hospital 19132 - P&P of who is authorized to make entries into medical record
leg doc (4) 3-27 939 /- fevi and 3-27 X-fevi weld 3-28

Facility Name Planned Parenthond - Indpls Surveyor Auch 1 Collen Date 327-2018
Surveyor Jack / Collen Date 3:17-2018
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ABORTION CLINC
DOCUMENT REQUEST ADMINISTRATION (pg. 3-of 4)
All documents and records need only be since last licensure survey. If any documents are in a binder or
folder, please tag the appropriate ones using the numbers next to each requested item.
Madical Stoff
Medical Staff 0172 – Medical director examines credentials for medical staff members for appointment
0174 – Medical director makes recommendations to governing board for appointment
0176 – Medical director must develop & maintain P&P for medical sta Services
0170 - INACIDAL AND SECTION OF CO. CO.
Laboratory
6310 - CLIA certificate or waiver
6316 - P&P for quality control and quality assurance for complexity of tests performed at facility
Dharman
Pharmacy 6318 - Designated professional person with prescriptive authority or pharmacist
responsible for control of drug stocks 6320 - P&P, record of stock supplies of all scheduled substances, incl. an accounting
- 114// - P.V.E. Hillighten to hundre, store idoor mistored adam arms
0324 - P&P for reporting of adverse reactions and medication errors to physician responsible for patient and
appropriate committee
#326 - P&P for drugs:
accurately and clearly labeled, stored in specially designated, well-illuminated cabinets, closets or
storerooms
b. in cabinets accessible only to authorized personnel
in cabinets for controlled Schedule II drugs and other drugs subject to abuse permanently affixed
compartments that are separately locked
Ld. if in carts with controlled substances, securely affixed
70328 - P&P for instructions to patient on use of take nome meas being the responsibility of prescribing physician
10330 - Documentation of formulary
9332 - List of available emergency drugs
Maintenance of Physical Plant
0406, 0408, 0410, 0414, 0416, 0418- See ABORTION CLINIC DOCUMENT REQUEST - PHYSICAL PLANT
WORKSHEET EQUIPMENT
0420 - Documentation of defibrillator discharge log in accordance with manufacturer's recommendation, with
initialed entries
1/2 Pariament 2->7
leg-doc(A1) 3-21 930 V- Reviewel 3-27 X-Reviewel 3-28
A-Keikensu 5-28

Facility Name 1/annel Parenthood Sudpls
Surveyor Jack 1 Collect Date 3-27-2018 ABORTION CLINC DOCUMENT REQUEST - ADMINISTRATION (pg. 4 of 4) **Epvironment** √0430 - Documentation of safety management program including periodic equipment inspections, insect, rodent or other vermin control, instructions for operating & maintaining the building or building portion & equipment, chemical substance use & storage, surgical waste & similar material disposal, general housekeeping precautions 10432 - Documentation of ongoing clinic-wide process to evaluate & collect information about hazards and safety practices 1/0434 - Documentation of safety program including patient, health care worker and public and visitor safety *6436 - Written fire control plan with provisions for prompt reporting of fires, extinguishing of fires, protection of patients, personnel & guests, evacuation, cooperation of firefighting authorities, fire drill documentation *10438 - Documentation of regular inspection and approval by state or local fire control agencies ≥0440 - Documentation of emergency & disaster preparedness coordinated with appropriate community, state and federal agencies 438 none Confirmed intervA2)
3.28 1152-no other for by exit

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Indiana State Department of Health

Abortion Clinic: Assaul Parenthood Date: 3 Date: 3/27

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Pacility Name Planned Parent Hood Indianapolis Surveyor Cach I low Date 3-28-2018

ABORTION CLINIC DOCUMENT REQUEST - CREDENTIAL FILE REVIEW

MD#	MD Name	Appt/ Reappt 0058	IN MD L10052 0062	IN CSR 0062	DEA Regist 0062	Edu/Trai n Exper 0060	Abort Clin Priv 0068	CPR -0168	Perf Rev 0170	
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	<u>VP of Patient Service</u>
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,	Health Come Asst
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CPR Certification Policy

April 21, 2017

Purpose

All staff providing direct patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) certified by the American Heart Association.

Policy

Staff must initially be BLS or Advanced Cardiac Life Support (ACLS) (if applicable) certified by the American Heart Association (AHA). All staff who are not certified at hire are required to obtain certification prior to beginning patient care. Staff must obtain AHA BLS or ACLS (if applicable) recertification prior to his/her CPR expiration date.

Center managers are responsible for the coordination of CPR training for his/her new employee during the new employee's scheduled work hours before the new employee may provide patient care. Certification outside of scheduled work hours requires pre-approval by the Regional Director and is determined on a case-by-case basis. Certification must be completed in the geographic region of the health center or the employee's home to prevent additional travel costs. PPINK will not reimburse for mileage or drive time to CPR training unless pre-approved by the Regional Director.

AHA BLS and ACLS courses may be found online; the AHA keeps a current list of instructors and courses at https://goo.gl/6dpRC1. The center manager may coordinate the payment of the employee's certification using PPINK's company card in advance, or the employee may pay for the certification and be reimbursed. The employee must submit this cost on an expense report and include a receipt. If applicable, center staff are required to attend PPINK-scheduled group CPR training unless otherwise approved by the Regional Director.

Once completed, the employee must submit verification of CPR certification in the form of a copy of the CPR card's front and back to his/her Center Manager. The Center Manager is responsible for sending a copy of the employee's card to the Human Resources Department and his/her Regional Director for tracking and filing. Failure to complete this certification within 30 days of hire (if not already certified) may result in suspension without pay or termination. Failure to obtain CPR recertification prior to the employee's CPR expiration date will result in immediate suspension without pay and may result in termination. The Regional Director must track the employee's certification expiration date on the Personnel File Tracking Spreadsheet.

Existing staff who begin applicable skills or are transferred to sites requiring CPR certification must follow the same process and must obtain certification prior to transfer or confirmation of additional skill/training (e.g. injection, venipuncture).

Workers' Compensation Medical Providers List

Prepared for:

Planned Parenthood of Indiana-and Kentucky 8590 Georgetown Road Indianapolis, IN 46268

EMPLOYEE NOTICE

ALL ACCIDENTS MUST BE REPORTED TO YOUR SUPERVISOR IMMEDIATELY!

FOR WORK RELATED INJURIES, MEDICAL SERVICES MAY BE OBTAINED FROM ONE OF THE MEDICAL FACILITIES LISTED BELOW:

If you require emergency medical treatment, go to the nearest hospital emergency room or urgent care facility.

Medical Providers

Concentra Medical Center Occupational/Industrial Medicine Urgent Care Center/Walk-In 5604 W 74th Street Indianapolis, IN 46278 317-290-1551 US HealthWorks Medical Group of Indiana PC

Occupational/Industrial Medicine 4850 Century Plaza Rd Ste 100 Indianapolis, IN 46254 317-297-1175 Medcheck Carmel

Occupational/Industrial
Aledicine
Urgent Care Center/Walk-In
11911 N Meridian St Suite
150
Carmel, IN 46032

317-621-6700

Marshall, Kenneth D., MD

Nova Medical Center Nova Medical Centers Occupational/Industrial Medicine 500 N Capitol Ave Indianapolis, IN 46204 317-983-5400

Pharmacies

AIG Claims, Inc. preferred Pharmacy PPO is TMESYS (Tim-a-sis). Please ask your Pharmacist to submit your prescription online.

Chris Pharmacy

CVS Pharmacy

Fagen Pharmacy

Food City Pharmacy

K-Mart Pharmacy

Kroger Pharmacy

Meijer Pharmacy

Rite Aid Pharmacy

Shop N Save Pharmacy

Walgreen Drug Store

If you come across any inaccuracies in the provider listing, please report them to us by contacting provider listing.



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container in which it is being held.

H. Quality Control Procedures

- Preparation of Control Solutions
 To prepare positive and negative control solutions for
 testing, first verify that the labeled expiration date for
 the solution is appropriate. This solution may be used
 as a positive centrol. To prepare a negative control,
 dilute one part of full strength solution with one part of
 water. Label each control solution appropriately.
- 2: Testing Procedure
 Following the Directions for Use, submerge three lest
 strips in each of the above freshly prepared solutions
 for one second each. Remove. The three strips dipped
 in the full strength positive control solution should
 exhibit a complete purple color on the indicating pad
 at 90 seconds. The three strips dipped in the diluted
 megative centrol should either remain completely blue
 or exhibit an incomplete color change to purple when
 read at 90 seconds. Refer to the color chart on the test
 strip buttle for interpretation of results.
 - 3. Teating Fraquency
 It is recommended that the testing of positive and
 regative controls be performed on each newly opened
 test strip bottle of CIDEX OPA Solution Test Strips.
 After this initial testing, it is recommended that testing
 of freshly prepared positive and negative controls be
 performed on a regular basis as established by your
 own quality control procedures and program. This
 testing program will serve to minimize errors between
 different users, use of outdated materials or product
 that has been improperly stored or handled.
 - 4. Unsatisfactory OC Test Performance
 If the results obtained from using the positive and
 negative controls indicate the test strip is not functioning
 properly, discard the remaining strips. Do Not Use
 Strips. For technical product information, contact
 Advanced Starilization Products at 1-888-783-7723.

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PLANNED PARENT CONTROL SUBSTANCE LOG 2018

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Instructions: Must be completed every procedure day by 2 staff members (2 licensed staff members, 1 licensed staff member and the health center manager or assistant manager) for all control substances. An unlicensed staff member may only complete the count if a licensed staff member. Health Center Manager, or Assistant Manager is not on site. Provider, and Health Center Manager should review log monthly and document review by signing and dailing below:

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Medical Director Reviews

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Date: 3 /23/18

PPINK revised DILS.

CPR Certification Policy

April 21, 2017.

All staff providing direct patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) certified by the American Heart Association.

Staff must initially be BLS or Advanced Cardiac Life Support (ACLS) (if applicable) certified by the American Heart Association (AHA). All staff who are not certified at hire are required to obtain certification prior to beginning patient care. Staff must obtain AHA BLS or ACLS (if applicable) recertification prior to his/her CPR expiration date.

Center managers are responsible for the coordination of CPR training for his/her new employee during the new employee's scheduled work hours before the new employee may provide patient care. Certification outside of scheduled work hours requires pre-approval by the Regional Director and is determined on a case-by-case basis. Certification must be completed in the geographic region of the health center or the employee's home to prevent additional travel costs. PPINK will not reimburse for mileage of drive time to CPR training unless pre-approved by the Regional Director.

AHA BLS and ACLS courses may be found online; the AHA keeps a current list of instructors and courses at https://goo.gl/6doRC1. The center manager may coordinate the payment of the employee's certification using PPINK's company card in advance, or the employee may pay for the certification and be reimbursed. The employee must submit this cost on an expense report and include a receipt. If applicable, center staff are required to attend PPINK-scheduled group CPR training unless otherwise approved by the Regional Director.

Once completed, the employee must submit verification of CPR certification in the form of a copy of the CPR card's front and back to his/her Center Manager. The Center Manager is responsible for sending a copy of the employee's card to the Human Resources Department and his/her Regional Director for tracking and filling. Failure to complete this certification within 30 days of hire (if not already certified) may result in suspension without pay or termination. Failure to obtain CPR recertification prior to the employee's CPR expiration date will result in immediate suspension without pay and may result in termination. The Regional Director must track the employee's certification expiration date on the Personnel File Tracking Spreadsheet.

Existing staff who begin applicable skills or are transferred to sites requiring CPR certification must follow the same process and must obtain certification prior to transfer or confirmation of additional skill/training (e.g. injection, venipuncture).

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ACMS-ROT (7-95)

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Facility Name:	Planne	()	Surveyor Nan	ne: Mar	vey Ot	ten
Provider Number			Surveyor Nun	aber: <i>372/</i>	Discipline:_	RN
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Indiana State Department of Health Personnel/physician identifier Table

Name of abortion clinic: flann	ed parenthood
Date of Survey 3/27-28	//8
Staff/Physician Name	Number assigned by surveyor
01/1 02 03 14 05	Dir Clin Services VP of it services Risk + qual Dr of Clin Ops Human Resoluces

M. Otters

. planned farenthood 3/27-28/18

ABORTION CLINIC MEDICAL RECORD REVIEW

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Procedures for surgical abortion must include preprocedure testing that					-	\sim	med			7	1
includes:	<u>/</u>	1	<u> </u>	1-7-							*
On-site proof of pregnancy as evidenced by a pregnancy test, a copy of a pregnancy test or an ultrasound	us	Ju.S	1	1-1		1/			1/	ام (
Verification and documentation of gestational age	12		H	4	1		1	1/			
Hematocrit or hemoglobin	+ 1			1					1		
Rh typing	1/2	1/	1/	1		/ /				1	
Completion of the abortion documented by ultrasonography	17	med		1 1				1	Med	1/	
or other clinical means	IV_	1	$\lfloor V angle$	V	V		V.	1/	NA"		
Provision of follow-up examination and services	Suran	1	V		MA	NA	V	1/		NA	
Preanesthesia evaluation within forty-eight (48) hours before a surgical	11/	NA	NA	1	**/	1/	Surg.	1	ىسى 1	Sum	
abortion	1		~	-	V_	/		1/	1		
History and physical examination report to include: Vital signs	1	-		1							٠.
Allergies	15-	1		+//-		1/-	1		1	-	
Any significant risk factors	14		1	1			1/			1	
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Anpropriate medical history	1/			1					4		
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Entries related to mesthesia administration in id valium	1/	NH	NK				141		NA	_'\/_	
Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)	1	1/	1/	1/	1/	1/	A MOP	.11	~/\	1/	
A report describing techniques, findings, and tissue removed or altered:	Cr	Yn	*	1	1		Thurst	10	V-41	4	
Authentication of entries by the physician or physicians and health care	1	18.54	<u>. ~ </u>		1	· /	**		171		
-workers who treated or cared for the patient.		V	1//	V_{λ}	V_{\perp}	1/	V	1			
Condition on discharge, disposition of the patient, and time of discharge,				V	V	V	V	. 1/2	1/	. 1/	
Discharge entry to include instructions to the patient or patient's legal	1	1/	1/	A	1/	,/	1/	1		1/	
representative.	V	ν	V	1	<i>ν</i>	V	•	V	<i>P</i> .	-	
Copy of the transfer form, if the patient was referred to a hospital or other facility.	NIA	NA	NA	NA	NH	MA	NA	NA	NA	NA	
Copy of the ferminated pregnancy report.	TOE ZON		100	1 1	-/		1 0			-	ì
Copy of any report filed with a state agency or law enforcement agency.	i sisé			1.0	V	A/A-	10	-1.5			•
pursuant to a statutory reporting requirement muno 12/3	इस्टी	MA	NA	NA	NA	MA	MA -	NA	MA	NA	•
Discharge information to include:			\								
Signs and symptoms of possible complications	NA	M	//				/	1/2	1.		
. Activities allowed and to be avoided	IV.	1/	ν_{-}	$ \nu $	V_{\perp}			. 0	1		
Hygienic and other postdischarge procedures to be followed	$ \nu $	$ \mathcal{V} $	V	1-/	V	1			1	V	
Clinic emergency phone numbers available on a twenty-	1	-			*		`	1	.	.	
four (24) hours basis	1	$V \perp$		V	$V \mid$		1/				
Follow-up appointment, if indicated	NA		V.	NA	NA	1/4	. 1/	NA		NA	
Counseling regarding RI: typing			V	r	V	أسنأ	1	1	1	1/	
Administration of Rh immune globulin, if indicated –	NA	NA	NA	NAS	NA	NA	NA	NA.	NA	N.A	
unless patient signs a waiver or other arrangements for	805		pog	100	P2	ps	pos	NAS	005	DOS	
administration are documented Conscious sedation	10.	<u>/</u>	P. 7		0-2	*	<i>y</i>			{ 	_
Frequent monitoring for verbal responses		NA	NA	-,/~	~ 4		NA	1	NA		
Monitoring for respiratory, cardiovascular and		1/4	CY CI	4/	1/	4		- ()	145	1/	
neurological effects of the drugs being used.	10	NA	NA	V [V	NA	V	14	V	
Postanesthetic evaluation for proper anesthesia recovery before discharge	1/	NA	NA	1	1/	12	N-A	V	NA	1/	
Form 56108 - Certification of Provision of Perinatal Hospice Information	$\uparrow \downarrow \uparrow$	· /		$\overline{}$			• • •				
(Time of Abortion Consent Decision)								<u>_</u>		لــــــ	
Form 56113 - Certification of Provision of Perinatal Hospice Information	/ ,]	$\rightarrow \not$						-7/	= 7		
Form 56114 — Disposition of Aborted Fetns Form 56115 — Available Counseling after an Abortion	14	1//	1/	1//	1	1/1	-		1//	W	
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ABORTION CLINIC MEDICAL RECORD REVIEW

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Patient identification to include:		-		<u> </u>		ļ			. 1	
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Procedures for surgical abortion must include preprocedure testing that	MUN	SWH	me							
includes: On-site proof of pregnancy as evidenced by a pregnancy	11100		1/		1	1				
test, a copy of a prognancy test or an ultrasound	1		V			u	V	1	V	
Verification and documentation of gestational age		·V	1/		V.			-1/	V	
Hematocrit or hemoglobin	17.	1	V.	1/	4111	V	12		1	7
Rh typing	VI	VT	V	10	V	1)	1	1/	
Completion of the abortion documented by ultrasonography	机格件	208	mell	1/	MA	4/		1/	1/	1/
Of Giller Clinical Means	147	V.	NH	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	411	V		1/4	K 2	·//
Provision of follow-up examination and services	V	NA	1/	Yesu	77.75	NH,	V Men	ĮV PK	/ / /	<u> </u>
-Preanesthesia evaluation within forty-eight (48) hours before a surgical	112		NA	1/	V	1/	JA	none	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
abortion History and abusing examination report to include:	V	<u> </u>	- 4	<i>V</i>		~				
History and physical examination report to include: Vital signs	ī	7	1	.7	1/	1 -				1/
Allergies	1/	1//	1/.	1/	3/.		1/	17		1/1
Any significant risk factors		1	W.				1/	Y/	1/	/
The date written	,	1	1/	1/		1/	1		1	
Appropriate medical history	V.	V	V.			- 13	V	1//	- 1	1/1
Results of a physical examination	Vr	100	NA	V_{\cdot}	1/2	1	NA		9	V_{ℓ}
Results of any diagnostic studies	LV_	NO	1/	VPOY		V	W/	<u> </u>	1/2	\$//
Results of any laboratory studies	V,	1//	1	Z	4	V	1	1/_		1/2
Any allergies and abnormal drug reactions	W _A	Y	1/1	V,	1	V,	5/4	1	1/_	
Entries related to anesthesia administration	LNA.	\mathcal{V}_{-}	14	, 1/	V_{\perp}	-	-14/1			
Byidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)	1/	\ \ /	1/		1/		1/		1	
A report describing techniques, findings, and tissue removed or altered.	: NA	Y_		1/1	1/		mood	1/	•//	1/
Authentication of entries by the physician or physicians and health care	17			1	./	. /			1	
workers who treated or cared for the patient.	.V .	- V.,	1		- V 🖊	V	-1/	. 1	· V	V /
Condition on discharge, disposition of the patient, and time of discharge.	V	V		V_{\cdot}	V	V	7	1	1/	<i>N</i>
Discharge entry to include instructions to the patient or patient's legal	1/	1		1 /		1/	1	i	. /	1/
representative.	<i>V</i>	V	V	V	* 4.4	<i>V</i>	V	V_{-}	V	V . A
Copy of the transfer form, if the patient was referred to a hospital or other	NA	NA	۸LA	Nu	ΛH^{\dagger}	NA.	NATI	144	NA	JP
facility. Copy of the terminated pregnancy report.	100				1/		· //	7771	17	1
Copy of any report filed with a state agency or law enforcement agency	1/A	-V		- V		Vac	17/1			1/4
pursuant to a statutory reporting requirement. 13 2	NAT	NA	NT	NA	NA	//	NIT	N4	MH	יי <i>ו ע</i> ן
Discharge information to include:			7							
Signs and symptoms of possible complications	V	/	1/	V	V,	ν	V/	1/	1/	V
Activities allowed and to be avoided			\mathcal{V}	1/_	V	1/	U	ν	\mathcal{V}	V,
Hygienic and other postdischarge procedures to be	1	1	1/	1/1	1/	1	2	17	17	<i>V</i>
followed	4	V	ν	* /	<i>V</i>			<i>V</i>	V ,	
Clinic emergency phone numbers available on a twenty-		سر(V		1,0		1	1/	
four (24) hours basis Follow-up appointment, if indicated	1	n IniA		NAY	NA	1	1	NA	NFA	NIX
Counseling regarding Rh typing		1. 1.		' X	4. 7	1	V	184		1
	1//1	1.4	.74	119	1/4	1/4	1/4	110	NA	XIV
Administration of Rh immune globulin, if indicated— unless patient signs a waiver or other arrangements for Rhoftin ? administration are decumented—	777	NAS	Vi	The state of	1005	105	1/4	NA	25	1
administration are decumented-	P07	Pe	POS	Migra	1 1	10-	par	July	gov.	pun
Conscious sedation						2017				<u> </u>
Frequent monitoring for verbal responses	MA	<u> </u>	NA	1/	NA	han I	PA	N/A	1/	
Monitoring for respiratory, cardiovascular and	MI	V	NLA		NA		NA	1	1/	V
neurological effects of the drugs being used.	A 10		11		~ A	-,/	VA.	V	1/	1
Postanesthetic evaluation for proper anesthesia recovery before discharge Porm \$6108 — Certification of Physision of Parinatal Lospice Information	/XI	¥	(V71	\prec	177	-V	-XI		/	<u>*</u>
Vorm 56108 — Certification of Provision of Parmatal Hospice Information (Time of Abertion Consent Decision)	/ \)	$(\) \]$	/ }	۱ ۱	ſ\!	/)
Form 56113 — Certification of Provision of Perinatal Hospice-Information	{}		12		/		\	/ /		
Form 56114 - Disposition of Aborted Fetus	1		V		V		1			
Form 56115 – Available Counseling after an Abortion					V				1/	1/
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ABORTION CLINIC MEDICAL RECORD REVIEW

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Patient identification to include:	2004	Jevuj_	nep	Siving	meg	Jan	MPA	Surry	Swy	meg
Name	-		•	<u></u>	·				-	-
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Address	1	1/	IV		17		17-		1	
Procedures for surgical abortion must include preprocedure testing that includes:									-	
On-site proof of pregnancy as evidenced by a pregnancy test, a copy of a pregnancy test or an ultrasound	V	V		Surg		1/		1	1	V
Verification and documentation of gestational age	V			1/	17				1	1
Hematocrit or hemoglobin	1/2	1	1/	1	1	10			1/	
Rh typing-		near	nell	17/	100	nez	1005			
Completion of the abortion documented by ultrasonography	1/	11/	1	17		sw z	15.	300	-	med
or other clinical means	I V		140°	V	V	300	V	ME	NA	
Provision of follow-up examination and services	Surar	Surge	med	NA	NA	NA		JA	NA	NA
Preanesthesia evaluation within forty-eight (48) hours before a surgical	VA	. /		1			110	. /	1	010
abortion	N.	V	WA	V	V	V	NA	V	V	NA
History and physical examination report to include:	\sim				17		-			
Vital signs	V	JZ.	1/			V	MA		V	
Allergies	V.	1	1/			1//	V			
Any significant risk factors	V	V	V	V.		-//	1	V.		V
The date written	1/-	1/2	V	1/	1/	V	V.	رمرا		V
Appropriate medical history		V,	V_{-}	$\square V$		~ V.	1	V.		
Results of a physical examination	V_{ℓ}	V.	MA	1//		V2		V		
Results of any diagnostic studies .	-VA			N.	V	*/	NA	1/.		NA
Results of any laboratory studies		~	مرسلم	$-V_{\mathcal{L}}$					1	1
Any allergies and abnormal drug reactions		4	LV.	V		V	<i>V</i> ,		V	
Entries related to anesthesia administration	VAON	~~	NA	IV	O well		NH	V	NA	MA.
Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1, State form 55320 (6-13) and 55321 (6-13)	1	· V,	V	V	V	V	1	V	V	12/4/
A report describing techniques, findings, and tissue removed or altered $ ho c$	V		NA	4	NA	1/.	NA			ACA
Authentication of entries by the physician or physicians and health care	1/	1/		3/	1		. /	2	1/	~ /
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Condition on discharge, disposition of the patient, and time of discharge.		11/	ŽV.	V		V	V.		1/	1/
Discharge entry to include instructions to the patient or patient's legal	4/	1/	1/	1		1/	1/		1/	
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Copy of the transfer form, if the patient was referred to a hospital-or other hollity.	M	M	MA	NA	NA	NA	NA	NΔ	NA	NA
Copy of the terminated pregnancy report.		V	1/		V	V	1/	(13X)		1
Copy of any report filed with a state agency or law enforcement agency	NIA	. 1 24	.11.	1/2	.1.	A 670	N-1-4	7/12	010	11
unsuant to a statutory reporting requirement.	14.41	\mathcal{M}	NA	(4)	NA	MA	141	(V,V)	Vz4	NA
Discharge information to include:		<u> </u>	$\sim_{\mathcal{I}}$	-						<u></u> ,
Signs and symptoms of possible complications	Y/	$V \downarrow$	1//	V	V	V	1/	1//		1/
Activities allowed and to be avoided	11	1/	. /				\mathbf{V}			
Hygicnic and other postdischarge procedures to be followed	V	1/	1/	1/	1	9/	1/	1/		1/
Clinic emergency phone numbers available on a twenty-		V	<u> </u>		1	,	,	V		
four (24) hours basis		T	1/	V	1/	V		1/		
Follow-up appointment, if indicated	1A	125	Y 1	01.0		A / A	2/12	V		-
Counseling regarding Rh typing	YIX I	Y 2	100	(*/*	74.3	(4.42	Yes	nov	200	1/
Administration of Rh immune globulin, if indicated—	1254		-V	<u> </u>	V-	100	v_{-}	V	ν	1/
unless patient signs a waiver or other arrangements for	141	の蝶よ	. Qho	A Sh	yes	40%	۸.۱۸	NA	1/1	11
administration are documented	/ W '		gain	1/	8		MA	1	142	[TTV]
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Monitoring for respiratory, cardiovascular and	- 	./-	7 1	.//	47	!	11 /	· V _ [144	NA
neurological effects of the drugs being used.		Y ,	NA	V_{\cdot}	V	V	NA	1/		-
ostanesthetic evaluation for proper anesthesia recovery before discharge	WV	\checkmark	NA	1/	1/	1/	AZZ	1	1	
orm 56108 - Certification of Provision of Perinatal Hospice Information					-		XE'S	V +	-	4
fime of Abortion Consent Decksion)										
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orm 561 N Certification of Provision of Perinatal Haspice Information										
orm 561 N Certification of Provision of Perinatal Haspice-Information orm 56114 – Disposition of Aborted Petus orm 56115 – Available Counseling after an Abortion	7 /	V	V	V^{\dagger}		1/	7/	1	1/	

Indiana State Department of Health Patient/Record Identifier Table

Name of abortion clinic: American Date of survey: 3/27-28/4 Type of survey: State Lea	of parenthood
Date of survey: 3/27-28/4	<i>8</i> .
Type of survey: State Lea	ensing
Patient's name	Number assigned by surveyor to
or	patient's name or
medical record number	medical record number
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ABORTION CLINIC 1	NURSING TOUR ZAT #5
FACILITY planned Parenthood SURV	BYOR Marry Otter
MED DIR MANAGER.	FOUR: DATE 3/27/18 TIME 1445
STAFFING: R.N. 2 LPN Tech 4	Ratio: 20 galleta 3/2
Traffic pattern Dressing areas/staff/patients Adequate supplies/storage Clean utility	Soiled utility Linen-Storage Handwashing sinks/toilets preventive maintenance
NUMBER OF PROCEDURE ROOMS	
PROCEDURE/ANESTHESIA/RECOVERY AREAS: Scrub area Dress code adherence Emergency call system Oxygen/humidifier bettles Resuscitation equipment Defibrillators (if IV Sedation is used) MACardiac Monitors (if IV Sedation is used) Pulse Oximeters (if IV Sedation is used)	Suction Equipment (if IV Sedation is used) Other supplies/equipment specified by medical staff (if IV Sedation is used) IV equipment Anesthesia agents used Sharps disposal Medication and narcotic storage/drug areas/stock supplies
OTHER: Clean/dirty instrument/sterilization areas Sterilizers Chemical/biological indicators Waste disposal; All types	
COMMENTS/INTERVIEWS: US profile - 2 guse " not doing (- laundry - blankets ont	Gack) . A g 14D, test gack) - Tude coldwater -
phone-interpreter per	vece + on site LWA
all MRs are scan in	
	- to m 2 - under 1515

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Shift		mday 3/	// Mond		·	nesday 3/13	· Wedne		14		day 3/	15		aý <i>3/1</i> /	Saturday	(
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Signature of	Staff:	Physicia	m			Date	Λ									

M. Otten

Indiana State Department of Health Abortion Clinic: Amend faventhood Date: 3/

Date: 3/27

Phy/ Exam Other CPR. Last Compe Immun PPD Hire Lic/ Orient In-Name/Class Prior 2 step tency eval Educ Date service cert 11/28/11 H S NA NA NA V11 V/2 N/5

planet parenthood con 3/27-28/18 my COPY

Abortion Clinic Nursing Document Request

Patient list/register for 4//// 3/26/18 List of all Nursing Personnel including agency for Andrew Complaint Log for 9////7 — Andrew Complaint Log for 9///// The complaint Log for 9///// The complaint Log for 9///// The complaint Log for 9///// The complaint Log for 9///// The complaint Log for 9//// The complaint Log for 9///// The complaint Log for 9//// The complaint Log for 9///// The complaint Log for 9//// The complaint Log for 9/// The complain
Incident Reports for 9/1/17 - fare and
Personnel policies including; The Policy for control of communicable diseases includes specific to TB Description and training of new employees, contract and agency personnel CPR policy Annual in-service requirements Mannual competency for nursing and other personnel performing lab tests
Patient care/nursing policies and procedures including; Composition of and meeting minutes for the patient care personnel committee Reliable method of ID Instruction for follow up care and transportation—to include counseling, RH type and administration of Rhogam Reporting of post procedure complications and follow up IV Cleaning and sterilization of reusable equipment
Infection control program and policies including: The Composition and meeting minutes of infection control committee last composition for active and effective Infection Centrol Program
Sterilization policies and procedures including; M Instructions for loading, operating, cleaning and maintaining sterilizers Instructions for cleaning packaging, storing, labeling and dispensing of sterile supplies Records of sterilization cycle and results of biological indicators in testing sterilization Cleaning of environmental surfaces contaminated by blood or infectious material
Anesthesia policies including; Wafety rules to be followed Safety training required of personnel CPR also Preanesthesia, intraoperative and post anesthesia policies and requirements
Pharmacy services policies including: - Records of stock supplies and accounting of all items - Policies for drug handling, storing, labeling dispensing and administration - Reporting of adverse reaction and medical errors - Storage and security - Formulary - List of available emergency drugs

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY SURGICAL CENTER EMERGENCY DRUG BOX

		Vanr
Upolth Contar	E .	Year

<u>Instructions</u>: This log is to be completed by licensed personnel monthly by adding a checkmark to each box in the column for that specific month as complete and by signing and dating the review below. Health Center-Manager to review log monthly. Health Center Manager should be notified if the Emergency Drug Box needs to be replenished of supplies as they expire or as they are used.

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct "	Nov	Dec
Oxygen tank w/gauge (>% full)			V									
Nasal cannula w/tubing (2)	_	-	V									
Non-rebreather face mask (2)			1/									
One-way valve mask (1)			1/									
Adult bag valve mask w/ reservoir (1)			V									
Airway set (1)			1/									
Tape-one roll			1/									
Scissors			V							1		
Exam gloves (latex free) (10 pairs)			V									
Alcohol pads (10)	-		V									
3 ml syringes w/ 21 gauge needle (5)			V									
TB syringes w/needle (5)			-	-		-			•			
4X4 sterile gauze (4)		-	V				-					-
Ammonia capsules (6) Also in surgical rooms.	-		V						-			
IV set and tubing (5)	-		V					-		•		
Filter Needles (4)												

Page 1 of 4

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY SURGICAL CENTER EMERGENCY DRUG BOX

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Health Center	1 Cui

Instructions: This log is to be completed by licensed personnel monthly by adding a checkmark to each box in the column for that specific month as complete and by signing and dating the review below. Health Center Manager to review log monthly. Health Center Manager should be notified if the Emergency Drug Box needs to be replenished of supplies as they expire or as they are used.

	 					 		 }
Tourniquet		′						
Anglocaths (18, 20, 22 gauge) (5 of each)	V		_	-		-		
Suture Kit (1)	V							,
IV fluid bags- 1 L (NS or LR) (2 of each) Expires: Lot #:	PR INGE							
Diphenhydramine 25mg caps/tabs (6) Expires: Lot #:	1	•	•			-		
Diphenhydramine HCL 50 mg/ml (4) Expires: Lot #:	1	•			-			
Epinephrine 1:1000 (1mg/ml) (4) Expires: Lot #:	V		-	٠		-	1000000	
Epi-pen 0.3mg –(2) Expires: Lot #:	1				-			
Atropine sulfate 0.4 mg (2) Expires: Lot #:	V							
Misoprostol 200 mcg (1 btt) Explres: Lot #:	V							
Methylergonovine 0.2 mg/mi (10) Expires: Lot #:	V				-			
Oxytocin 10 units/ml -(6) Expires: Lot #:	1/							
Albuterol inhaler (MDI) (2) Expires: Lot #:								

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY SURGICAL CENTER EMERGENCY DRUG BOX

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Health Center	Year
that specific month as complete and by signing and da	ersonnel monthly by adding a checkmark to each box in the column for ting the review below. Health Center Manager to review log monthly. gency Drug Box needs to be replenished of supplies as they expire or as

Pitressin (vaopressin) 20 units/ml (5) Expires: Lot #:		1	-	-	•	-			manda (Antaria)
Moderate sedation only Narcan (naloxone) 0.4mg/ml (2) Expires: Lot:		1							
Mild and Moderate sedation only Romazicon (flumazenil) 0.1 mg/ml (1) Expires: Lot #:		V					-		
Juice Expires:	-								ALONGO PARTIES AND AND AND AND AND AND AND AND AND AND

^{*}If an expiration date exists document it on this form

Staff Printed Name	Staff Signature	Initials	Date	
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PLANNED PARENTHOOD OF INDIANA AND KENTUCKY SURGICAL CENTER EMERGENCY DRUG BOX

Health Center		Year		
structions: This log is to be completed b	by licensed personnel monthly by adding a cigning and dating the review below. Health (difference of the Emergency Drug Box needs to be rep	Center Manager to review log monthly.		
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CPR Certification Policy

April 21, 2017

Purpose

All staff providing direct patient care must be Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR) certified by the American Heart Association.

Policy

Staff must initially be BLS or Advanced Cardiac Life Support (ACLS) (if applicable) certified by the American Heart Association (AHA). All staff who are not certified at hire are required to obtain certification prior to beginning patient care. Staff must obtain AHA BLS or ACLS (if applicable) recertification prior to his/her CPR expiration date.

Center managers are responsible for the coordination of CPR training for his/her new employee during the new employee's scheduled work hours before the new employee may provide patient care. Certification outside of scheduled work hours requires pre-approval by the Regional Director and is determined on a case-by-case basis. Certification must be completed in the geographic region of the health center or the employee's home to prevent additional travel costs. PPINK will not reimburse for mileage or drive time to CPR training unless pre-approved by the Regional Director.

AHA BLS and ACIS courses may be found online; the AHA keeps a current list of instructors and courses at https://goo.gl/6dpRC1. The center manager may coordinate the payment of the employee's certification using PPINK's company card in advance, or the employee may pay for the certification and be reimbursed. The employee must submit this cost on an expense report and include a receipt. If applicable, center staff are required to attend PPINK-scheduled group CPR training unless otherwise approved by the Regional Director.

Once completed, the employee must submit verification of CPR certification in the form of a copy of the CPR card's front and back to his/her Center Manager. The Center Manager is responsible for sending a copy of the employee's card to the Human Resources Department and his/her Regional Director for tracking and filing. Failure to complete this certification within 30 days of hire (if not already certified) may result in suspension without pay or termination. Failure to obtain CPR recertification prior to the employee's CPR expiration date will result in immediate suspension without pay-and may result in termination. The Regional Director must track the employee's certification expiration date on the Personnel File Tracking Spreadsheet.

Existing staff who begin applicable skills or are transferred to sites requiring CPR certification must follow the same process and must obtain certification prior to transfer or confirmation of additional skill/training (e.g. injection, venipuncture).



200 South Meridian Street, Suite 400, Indianapolis, IN 46225 Mailing Address: P.O. Box 397, Indianapolis, IN 46206-0397 p: 317.637.4343 - f: 317.637.4344 www.ppink.org

Planned Parenthood of Indiana and Kentucky

May 16, 2018

To Whom It May Concern:

Please see the enclosed Plan of Correction as a response to the Statement of Deficiencies report received March 28, 2018 for Planned Parenthood of Indiana and Kentucky's Georgetown Facility (#160111181).

Our contact for questions on these documents is

Kind Regards,

Respons	Response to ISDH Abortion Licensing Review conducted March 29, 2018 Survey results received May 15, 2018	March 29, 2018		
#	Problem Identified	Corrective Action	Responsibility	Date of Correction
	4 Current license not posted in waiting room	New license posted during suvey	Health Center Manager	3/29/2018
134	434 One of thirty audited medical records was missing one State Form (form 55320)	Staff re-educated on consent requirements during staff meeting; ISDH consents added to quarterly abortion medical record audits	Health Center Manager, Risk and Quality Manager	6/1/2018
1,44	144 Nurse Practitioner did not have completed ennual review	Annual reviews completed for all staff in May 2018, will be completed annually thereafter M.Own + Oc	Human Resources	6/1/2018
168	168 Two staff members did not have CPR certification proof in their personnel files	Staff have completed CPR settification and a copy has been placed in the personnel file	Human Resources Who	6/1/2018
206	206 Test strips not being used in Cidex solution	DISPUTED CO.		
320	320 Controlled substance log missing two signatures on some lines	Updated pharmaceuticals policy implemented 5-15-18 to improve clarity around documentation of pharmaceutical inventory, including controlled substances [Mon.]	Director of Clinical Services 5/15/2018	5/15/2018
404	404 Unsecured oxygen tank in hallway	Oxygen tank was secured in chain during survey.	Health Center Wanager	3/29/2018

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dato changed in the space provided on the label.

container in which it is being hold.

11 quality Control Procedures

- 1. Preparation of Control Solutions
 To propose positive and negative control solutions for
 testing, first verily that the labeled expiration date for
 the solution is appropriate. This solution may be used
 as a positive chaired. To propose a negative control,
 dilute one part of full strangth solution with one part of
 water, Label user, sontrol solution appropriately.
- 2. Testing Procedure
 Following the Ofractions for Use, submorge three test
 strips in each of the above freshly prepared solutions
 for one sectond each. Remove. The three strips dipped
 to the totl strength positive control solution should
 exhibit a complete purple color on the indicating pad
 at 90 seconds. The three strips dipped in the diluted
 negative control should either remain completely time
 or exhibit an incomplete color change to purple when
 read at 90 seconds. Relar to the cutor churt on the test
 exchange to this for interpretation of results.
- read at 90 seconds. Relar to the cuter chort on the test strip bottle for interpretation of results.

 2. Testing Prequency **

 It is recommended that the testing of positive and negative controls be performed on each newly spaned test strip bottle at CIDEX OPA Solution Test Strips. After this initial testing, it is recommended that testing of freshly prepared positive and programs controls be performed on a regular health as well-volkshed by your own quality control prosedures and program. This testing program will serve to minimize errors between different users, use of outdated materials or product that has been improperly stored of handled.

 4. Unsatisfactory OCTest Performance
- Annual rise seen improperty state of interests.

 If the results obtained from using the positive and negative controls indicate the test strip is not functioning property, disears the remaining strips. Do Not Use Strips. For technical product reformation, contact Advanced Staritzation Products at 1-888-783-7723.

Planned Parenthood of Indiana and Kentucky, Georgetown Facility #160111181 IDR for ISDH Abortion Ucensing Review conducted March 29, 2018 Survey results received March 15, 2018

Tag ag	Severity/Scope	Response
206	It was observed in an ultrasound room there were tes strips being used to test the effectiveness of Cidex, th manufacturer's recommendation in the package inser indicates controls must be performed; facility not performing controls	It was observed in an ultrasound room there were test strips being used to test the effectiveness of Cidex, the manufacturer's recommendation in the package insert indicates controls must be performed; facility not performing controls Package insert (attached) reads: "Testing Frequency - It is recommended that the testing of positive and negative controls be recommended on each newly opened bottle of Cidex OPA Colution Test Strips." Recommended means this is a suggestion, not a requirement performing controls

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PLANNED PARENTHOOD OF INDIANA AND KENTUCKY 964 MEZZANINE DRIVE LAFAYETTE, INDIANA

STATEMENT	itate Department of He of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		013765	B, WING		03/0	7/2018
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T 000	INITIAL COMMENTS		Т 000			
	This visit was for a St	ate licensure survey.				
	Facility Number: 013	765				
	Dates of Survey: 3/5	5/2018 to 3/7/2018				
	QA; 3/15/2018				:	
T 144	410 IAC 26-8-1 PERS RECORDS	SONNEL POLICIES AND	T 144			
	410 IAC 26-8-1(o)(1)					
	reporting responsibilit annual performance evalu	the following: nt job descriptions with iles for all personnel and uations, based on the job employee and contract and				
	facility failed to provi out of 3 eligible emploant 1. Review of the 201 Employee Handbook Performance Evaluat receive an annual pe their immediate supe	review and interview the de an annual evaluation of 2				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT	itate Department of He of DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		013765	B. WING		03/07/2018
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	in the employee's per	sonnel file.			
	2. Review of P50, He	ealth Care Manager's job under Essential Functions:			
	Prepares disciplinary				
	provides indicated ma	anagement follow-up.	^		
	Review of P50 and personnel files lacked evaluation completed	d P52, Health Care Assistant I documentation of an In 2017 or 2018.			
	Interview with P50 Clinical Services on Confirmed lack of every personnel file and the	3/06/18 at 3:20 pm luations in P60's and P52's			
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	Provider Number		- Surveyor Nu	nber 144	145	Discipline PHNS	
	Observation Dates:	From 3/5/	2018	To 3/7	⁷ /2018 ⁻	ARMIN	
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SURVEYOR NOTES WORKSHEET

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Abortion Clinic Administrative Document Reques

Administrative Document Request
List of credentialed staff for CUTCH 2018 List of non-nursing Personnel for See Nrkg (IAM My) notes)
Ownership—copy of articles of incorporation Ouality assurance plan and documents to include all services/function/contracts Ukist of contracts with scope and nature of services
Sonstitution and bylaws of governing body (if applicable) Minutes of governing body (if applicable)
Process for reporting health professionals Written policy addressing internal review of unusual occurrences and disasters (AIMS Auptrumy)
Medical Staff Rules including; We Procedures for emergency, initial treatment, transfer (policy /) We History and physical
Mauthentication of orders, who may take verbal orders Who lies and procedure for communication with and timely response of physicians concerning a pt emergency
Health care worker practice problems The hysician Credentialing (if physician performs procedures): verify admitting privileges in writing OR a written agreement with another physician with admitting privileges. The document(s) must be present in the clinic.
Medical records policies including; Description of care and services provided Description of care and services provided Description of care and services provided Description of care and services provided Description of records from sources of damage Stordard policies 5.1.1 Description of records for appropriate time frame frame frame frame frame frame frame frame frame frame frame frame frame frame frame
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Lab policies including; DCLIA certificate or waived DQuality control and QA policies for complexity of tests Lab Comp I-CDD
Physical plant/Safety policies including; If Preventative maintenance policies/logs If Repairs and electrical leakage checks If Housekeeping and infectious waste policies (reviewed by If Equipment inspection If Vermin Control (lest flutted) If Building operations If Chemical substance use/storage
El Surgical waste disposal El General housekeeping (revrewed by Nrg) El Fire control plan AND Evidence of state or local fire inspection \[\local{10} \] El Emergency/disaster preparedness \[\local{10} \] Dents + Titrondon
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Surveyor GRACE PUSSELL PN, PHNS

Date 35-3/7/18

ABORTION CLINIC DOCUMENT REQUEST - CREDENTIAL FILE REVIEW

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Planned Parenthood of Indiana and Kentucky Medical Standards and Guidelines

PPFA revised June 2016/PPINK Implemented December 19, 2016

Kentucky (PPINK) have	I, , Medical Director for Planned Parenthood of Indiana and Kentucky (PPINK) have reviewed and approve the PPINK Medical Standards and Guidelines and all associated documents.						
., Medica	Director						
11/28/2016 Date							

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

JOB TITLE:

Health Center Manager

REPORTS TO:

Regional Director

<u>FUNCTION:</u> Responsible for overall management of one or more health center sites, including supervision of health center staff.

ESSENTIAL FUNCTIONS:

 Monitors the quality of medical care and compliance with agency standards and guidelines, policies and procedures.

- Manages overall performance of one or more Planned Parenthood of Indiana and Kentucky health centers, including achievement of goals related to patient numbers, productivity standards, and health center donations.
- Manages health center budget. Assists Regional Director with development of budget.
- Responsible for health center performance including the display of teamwork, quality of new hires and turnover ratio.
- Hires, trains, supervises, and terminates health center staff, contract employees and volunteers.
- Participates in the recruiting process by managing applicant flow and providing HR with feedback on interviewed applicants in a timely manner.
- Submits accurate and timely payroll, including time card adjustments.
- Manages staffing to include finding replacements, reassigning staff to other sites as workflow necessitates, and ensuring staff are cross-trained.
- Prepares disciplinary and performance improvement documents independently and provides indicated management follow-up.
- Maintains knowledge of Planned Parenthood of Indiana and Kentucky policies, governing values and strategic plan.
- Develops and fosters community relationships through participation in community groups, presentation of education programs, working with local media.
- Performs direct patient care duties as part of everyday responsibilities.
 Including performing laboratory testing (Hct, urine dipstick, PTs, B/P, wt, blood drawing), specimen handling and processing, reporting and follow-up of Pap smears, blood work, GC, CTT, herpes testing, and other diagnostic tests as indicated without supervision.
- Conducts QA audits, develops corrective action plans as necessary, and advises QA Coordinator on progress of deficiencies;

- Completes and makes corrections to maintain accuracy of all reports and forms, including timesheets, monthly summaries, supply requisitioning, etc.
- Maintains control over health center funds and other assets including petty cash, ordering and inventory.
- Conducts inventory counts and reconciles errors as necessary.
- Maintains medical records system and ensures the appropriate safeguarding of documentation.
- Maintains and sends all employee documentation to HR for placement in the employee's personnel file.
- Disseminates information to health center staff through regular meetings and other means.
- Maintains all facilities and equipment through the landlord and other service representatives.
- Ensures completion of day sheets on a daily basis.

*Nothing in this job description restricts management's right to assign or reassign duties and responsibilities to this job at any time.

EDUCATION AND EXPERIENCE:

Requires a high school diploma, with 2-4 years of experience and appropriate training in the health care field or a related area. Management experience preferred. Experience with standard business equipment and software programs preferred, including electronic practice management and health record systems.

REQUIRED COMPETENCIES:

DEVELOPING/DIRECTING OTHERS: Strives to improve the skills of subordinates or others by providing clear, behaviorally specific performance feedback, effective coaching and mentoring, and development-experiences and opportunities. Uses interpersonal style and the power of one's position to set expectations for others, enforce standards, and tell others what they must do towards the accomplishment of identified goals and objectives. Ensure that ethics and honesty are valued and exhibited in work products and daily behavior of self and others.

customer needs in a manner that provides satisfaction. Anticipates additional needs of the customer beyond their current use of Planned Parenthood of Indiana and Kentucky services. Understands and finds solutions within the limits of what is available. Can solve problems-with minimal disruption. Communicates openly and directly. Able to change communication style according to the needs of the audience and the situation.

TEAMWORK: Able to gain cooperation from others and work collaboratively toward solutions which generally benefit all involved parties. Proactively identifies opportunities to assist others and ensures that information is communicated accurately and timely to all necessary parties. Behaves honestly and ethically. Communicates openly and directly. Able to change communication style according to the needs of the audience and the situation.

PLANNING AND ORGANIZING: Establishes a systematic course of action to accomplish specific objectives. Determines priorities and uses time effectively. Completes the workload required of the position. Able to change priorities according to the work load and asks for assistance as appropriate.

ACHIEVEMENT ORIENTATION: Self-starting. Independently demonstrates a desire to set and meet objectives, to find a better or more efficient way to do things, and to compete against a self-defined standard of excellence.

ATTENTION TO DETAIL: Thorough in accomplishing a task. Double checks work before turning in. Accurately completes all areas involved no matter how small.

EXPERTISE (Technical or Procedural): Possesses specialized knowledge or skills to accomplish a result. Picks up on technical things quickly; is good at learning new skills. Often referred to as a "quick learner".

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to sit and talk or hear. The employee is occasionally required to stand; walk and reach with hands and arms. The employee must frequently lift and/or move up to 10 pounds and occasionally lift and/or move up to 25 pounds. Specific vision abilities required by this job include close vision, distance vision, depth perception and ability to adjust focus. The noise level in the work environment is usually moderate.

SPECIAL REQUIREMENTS:

Ability to maintain confidentiality of all Planned Parenthood of Indiana and Kentucky business and activities on and away from the job. Regular attendance during designated working hours is required.

LICENSES:

CPR Certification

REVISION DATE:

September 2014

HOURS:

full-time

OVERTIME EXEMPT:	Yes	
Employee Printed-Name	(plaase print clearly)	
⊨nαpιoyee's Sigπature	,	<u>Ue-27.16</u> Date
Supervisor's Signature	_	Date

Facility Name_ <u>PlONNE</u>	parentho	od-Lafayette
Surveyor Tanny Box	ber RN	Date 3/5-3/1/18
· .	ABORTION CLINIC SIGN IN SHEET	Fac# 013765
NAME (Print)	TITLE (Print)	
	Hea	14h Center Manager
	Dir. of C	linical Services
	VP of	Patient Services
	Dir. of	Clinical Operations
	Health C	ento Manage
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Indiana State Department of Health Patient/Record Identifier Table

Name of abortion clinic: Planned Parenthood

Date of survey: 3-5-18 to 3-7-18

Type of survey: State Survey:

1	Patient's name or medical record number	Number assigned by surveyor to patient's name or medical record number
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Fac# 013765

ABORTION CLINIC MEDICAL RECORD REVIEW

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Patient identification to include: Name		1/		V				1/	1/2	-
Age	"	' '/ '		, ,			, ,	1 12		•
Address	ν' I	W I	1/	ΙV		10/		V	1 1/	1 V
Procedures for surgical abortion must include preprocedure testing that			V							
includes:										
On-site proof of pregnancy as evidenced by a pregnancy	1			٠,٠						س، ا
test, a copy of a pregnancy test or an ultrasound	γ,	_/_	<u> ''</u>	V	······	V /				ļ-,
Verification and documentation of gestational age (以/.)	V I	V	v.	V:	/	<u> </u>	1, 1		1 1/	1 1/
Hematocrit or hemoglobin										
Rh typing Completion of the abortion documented by ultrasonography		7427	V		7	~ ,	ST 13	ナーツ		7
or other clinical means (7.657.00)	V	V.	V,	1	V,	1/	Sour	' / <i>/</i>		V
Provision of follow-up examination and services	1/2/1	failed	V	1/	V					1.7
Preanesthesia evaluation within forty-eight (48) hours before a surgical					-				J	
abortion										
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Vital signs (심)	V,	V	٧,	V/	<u>, , , , , , , , , , , , , , , , , , , </u>	_V		1/	1/4	.0
Allergics	1/	V,	V i	V	ν	1//	1//	- 1/-	بركل	1,0
Any significant risk factors (Wytten in Ced)	1/	V	./		' '		' ' '		./	1 12
The date written			**	· - / -		·				
Appropriate medical history	1/	- <u>Y</u>	V	<u> </u>		<u> </u>		- Lar	<u> </u>	1/
Results of a physical examination										<u> </u>
Results of any diagnostic studies Results of any laboratory studies	V	7	7	7	1/	./	-,/		- 10	1
Any allergies and abnormal drug reactions	nr.	i)r:	F11	100	V10	M	Λ'n	(10)	1/1/1	1/1
Entries related to anesthesia administration			1 1 (-			-1		الماسية الماسية		
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required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)		<i>V</i>	V	V	V	, ,	γ	\ <u>/</u>	v	V.
A report describing techniques, findings, and (Issue removed or altered.						<u> </u>				
Authentication of entries by the physician or physicians and health care	V	./	V				1/	V		
workers who treated or cared for the patient. Williams		/	· · · · · · · ·	4/						
Condition on discharge, disposition of the patient, and time of discharge.	\mathcal{N}_{+}	V	1/	ν,	<i>J</i> ,		¥*,		~~	L
Discharge entry to include instructions to the patient or patient's legal	./ I			√	\checkmark	V	/	V	V	14
representative. Copy of the transfer form, if the patient was referred to a hospital or other					100	200				
Copy of the transfer form, if the patient was referred to a nospital of outer facility.	/]		/,	//	//	//	//	/,		
Copy of the (erminated pregnancy report. (FM on every here) (370)	-J.Z	V			V	V	1	V	7	E/
Copy of any report filed with a state agency or law enforcement agency	- Y									
pursuant to a statutory reporting requirement.									ļ	L
Discharge information to include:										-
Signs and symptoms of possible complications	1/	<u> </u>	1//	1/	1/_	14	1/		1	1
Activities allowed and to be avoided (0.1) and also to	1/	_V	-1/_	V	·V			V .	10	1
Hygienic and other postdischarge procedures to be		√ :	W	V,	V	V .		V	/	1
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four (24) hours basis (W/(4) 17) (V/) (5 form)	V.	V/	V	V.	, ,	V	V.	V,	1/	1
Follow-up appointment, if indicated	1//	ブァ	1/1	V.	1	1/2	17	10/	1/	
Counseling regarding Rh typing	V	V	Ĭ.	1/	V	V	1	L/	100	V
Administration of Rh immune globulin, if indicated -	1	/	1	1	1./	V	1	1	1	
unless patient signs a waiver or other arrangements for	✓ .	√	V	V] V	k	 √	V	\vi	1
administration are documented				ļ		<u> </u>	 	ļ	_	╀—
Conscious acdation							<u> </u>		 	-
Frequent monitoring for verbal responses			ļ		 	<u> </u>	 `	1	 	-
Monitoring for respiratory, cardiovascular and neurological effects of the drugs being used.				1	 	ļ	 	 	 	
REBUTATORICAL CHECKS OF THE OFFIES DOING USED.					 		1			
Destruction for proper asset being recovery before discharge		 	 	†		 				1
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Postanesthetic evaluation for proper anesthesia recovery before discharge Form 56108 – Certification of Provision of Perinatal Hospice Information						1	L		<u> </u>	
Postanesthetic evaluation for proper anesthesia recovery before discharge Form 56108 – Certification of Provision of Perinatal Hospice Information (Time of Abortion Consent Decision)	,		/						,,	
Postanesthetic evaluation for proper anesthesia recovery before discharge Form 56108 – Certification of Provision of Perinatal Hospice Information	<i>J</i> ,	V.	1//	V/	1	√/	V,	V,	1,	V

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09/09/2016

ABORTION CLINIC MEDICAL RECORD REVIEW

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Address	V'	1	/	ļ	 	<u> </u>	 	_		
Procedures for surgical abortion must include preprocedure testing that includes:		 	<u> </u>		ļ		ļ	ļ		
On-site proof of pregnancy as evidenced by a pregnancy test, a copy of a pregnancy test or an ultrasound	W	V	V,							
Verification and documentation of gestational age	V	.V.	V.			ļ	<u> </u>			ļ
Hemajocrit or hemoglobin				 	<u> </u>	 		 	<u> </u>	<u> </u>
Rhtyping	1			<u> </u>	ļ	ļ	<u> </u>			
Completion of the abortion documented by ultrasonography or other clinical means	你們	04//	V.						1	
Provision of follow-up examination and services	יכועץ	/-	1:/	<u> </u>	 		 		,	
Provision of follow-up examination and services Preanesthesia evaluation within forty-eight (48) hours before a surgical		V		 -	1	+	 		 	
abortion										
History and physical examination report to include:		<i>-</i>								<u> </u>
Vital signs	<u> </u>		V	ļ	ļ		ļ	ļ	<u> </u>	ļ
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Any significant risk factors		1 1/	1 1/	1	<u> </u>	<u> </u>	 	<u> </u>		ļ
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Appropriate medical history		1			 	 	 			
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Results of any diagnostic studies	1	1	$- \checkmark$	 	 	 	 		 	
Results of any laboratory studies Any allergies and abnormal drug reactions	V112	00	1.40	 	 -	-	1			
Entries related to anesthesia administration	N. C12	7	 	1	<u> </u>					
Evidence of appropriate informed consent for procedures and treatments as required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)	V	V	V							
A report describing techniques, findings, and tissue removed or altered.		i								
Authentication of entries by the physician or physicians and health care	1.7	J	V.		T -					
workers who treated or cared for the patient.		<u> </u>	V /	<u> </u>	<u> </u>		ļ		ļ	<u> </u>
Condition on discharge, disposition of the patient, and time of discharge.	W,	V.	V.		<u> </u>				.	
Discharge entry to include instructions to the patient or patient's legal representative.	V	V	v'						<u> </u>	
Copy of the transfer form, if the patient was referred to a hospital or other	1	<i>j</i>		,						
Conv of the terminated pregnancy report. (FIX ON EXECUTION NO.)	100	<i>1</i> V	V							↓
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pursuant to a statutory reporting requirement. 13 04 V Apliow VIIS	4	1 /	/	 	.	 		 		
Discharge information to include:	ν,	+V/-	<i>V</i>	 	 	 	 	 		
Signs and symptoms of possible complications	1//	1-1/-	1-14/-	┼	 	 	 	 -	+	
Activities allowed and to be avoided	 	 1/,-	1-1/	 	1			 	1	1
Hygienic and other postdischarge procedures to be followed	V	V,	V		<u> </u>		ļ			<u> </u>
Clinic emergency phone numbers available on a twenty-	V,	1/	W							
four (24) hours basis Follow-up appointment, if indicated	17/	1 V/	1/,	1	1	T				
Counseling regarding Rh typing	10	17	Tiv.	\top						
Administration of Rh immune globulin, if indicated –	7	1	17							1
unless patient signs a waiver or other arrangements for	1.7	11/	V							1
administration are documented	V	<u> </u>	<u> </u>	1			J	 	 	-}
Conscious sedation	-	<u> </u>	_	 	<u> </u>	-			+	
Premient monitoring for verbal responses		 	 		 	+		 	+	+
Monitoring for respiratory, cardiovascular and neurological effects of the drugs being used.				1	<u> </u>	ļ		ļ	<u> </u>	
Postanesthetic evaluation for proper anesthesia recovery before discharge		ļ	 	_			 	 		+
Form 56108 – Certification of Provision of Perinatal Hospice Information (Time of Abortion Consent Decision)						1				<u> </u>
Form 56113 - Certification of Provision of Perinatal Hospice Information	,	1								+
Form 56114 - Disposition of Aborted Fetus	1 4	TV,	V/	 				-		
Form 56115 - Avnitable Counseling after an Abortion	$1 \overline{1}$	$1 \times I^-$	$\perp \nu$	1	1	1	1 .	1	1	ــــــــــــــــــــــــــــــــــــــ

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Facility Name	anned taxenthood Surveyor Name Tammy Berber, RN	
Provider Number	Surveyor Number 35731 Discipline PHNS	
Observation Dates:	From 3-5-18 To 3-1-18	
	State Survey	
TAG/CONCERNS	DOCUMENTATION	
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25-18		
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Facility Name $\mathcal{P}(Q)$	uned f	Parenthood		Surveyor Name	Tammy Berber, RN	_
Provider Number	<u> </u>	Surveyor Nu		35731	Discipline PHNS	(2)
Observation Dates:	From	3-5-18	To _	3-7-18	Chata Cura 18.1	
TAG/CONCERNS	<u> </u>		ne	DCUMENTATION	Stateshirty	
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Fac#013765

Facility Name	anna	Haventhor	\mathcal{A}	Surveyor Name	Tammy Berber, RN	(3)
Provider Number		Nun 11	yor Number	35731	Discipline PHNS	
Observation Dates:	From	3-5-18	То	3-7-18	O(1/2)	
		,			State Survey	
TAG/CONCERNS			DO	DCUMENTATION	,	_
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B. The Half life of Rho(D) immune globulin is 24 days, although

Fac#013765

Facility Name	anned	Parenthon		Surveyor Name	Tammy Berber, RN
Provider Number		Surveyor Nu	mber	35731	Discipline PHNS
Observation Dates:	From	3-5-18	To _	3-7-18	al is
					State Junier
TAG/CONCERNS			DO	OCUMENTATION	
3-10-18	Stan	dard dose of	Yahi	ent	
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W.	Camp	ilications-Eat	14/	Day of about	ion)
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	advi	se continued	Man	itoring of b	leeding & re-evaluate
	Lia a	nother. L to a	hou	rs Remove	tissue from vagina
	Or CE	inuix, H pres	ent,	Consider m	epeat dose of
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	24-7	12 hours as	indic	ated. It he	any bleeding persists?
	14 ho	Drs or symp	tonis	/signs of h	ypovolemia; reter
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	pelvi	e intection	SUS	pected.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

: Fac#0/3765

	S	SURVEYOR NO	TES W	<i>ORKSHEET</i>	- 1 UCH 015 165
Facility Name	anned Par	renthonal		Surveyor Name	Tammy Berber, RN
Provider Number	TO MICON 1 - ST	Surveyor Numbe	r 35	731	Discipline PHNS
Observation Dates:	From 3	-5-18 T	o <u>3</u>	7-18	(1)
					State Survey
TAG/CONCERNS			DOCUM	MENTATION	
3-6-18	Training	Ch 6 Perso	nnel		
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	amedia	al abortion	, <u>, , , , , , , , , , , , , , , , , , </u>	~~~~(MINISTERNATION
		may water the	, ,		

SURVEYOR NOTES WORKSHEET

Fac#013765

Facility Name	anned faverthood Surveyor Name Tammy Berber, RN
Provider Number	Surveyor Number 35731 Discipline PHNS
Observation Dates:	From 3-5-18 To 3-7-18 State Servey (8)
TAG/CONCERNS	DOCUMENTATION
3-10-18	Into prier to:
248	The torms are pre printed-so we can pick+
	Choose what to give them.
<u>.</u>	
320	Medical Creditial Files for Grace
,	
435	Both -> completed her area of exit r/t personnel
	performance evaluations
	Discussed atry meeting r/t pt care, IC &
	THE COUNTY
	Lett-tacintya 445
2 M-18	Arrived @ facility @ 930@ facilities request again
3-17-18	Arrived @ tacility@ 9 @ tacilities regularing
	Reviewed Incidents & Grace
	Discussed MR + NOW UP For TESCENS TO INCIDENTS
	Source of the trace of the same
	Discussed & Grace MR neview 7 & in education
	Selection -> Drop down, records prior to 11-2017 were imputed manually and a small check box indicated
	ots received Discharge / Post Information along c.
	124 Smergency Phone of Beth reviewed a Chart that
	Hollowed up the next clay to the patient to ensure
	the patient received the help/intermation needed.
	The tacility tilled out the proper torm & put in
	Lorland up the next clay to the patient to ensure the patient received the help/information needed. The facility filled out the proper form & put in pts chart.
	1
	Calculation to a three sound and to
1020	Per : retention doesn't need to be reported to
	13 14 yr olds for the entire year.
<u></u>	110,14 11 0105 tot the entire year.
	V 1/1/101

Fac#013765

O	SURVEYOR NO	TES WORKSHEE'	T
Facility Name	inned Harenthand	Surveyor Name	Tammy Berber, RN
Provider Number	Surveyor Number	35731	Discipline PHNS
Observation Dates:	From 3-548 To	3-7-18	9)
			State Survey
TAG/CONCERNS		DOCUMENTATION	14 18
3-7-18	The facility did ha	110 \ UV DO	d from June - Feh.
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	11Pac of 13:14 + 16		· · · · · · · · · · · · · · · · · · ·
	There was our	<u> </u>	of them had their
		and-/Bally	eviewed)
			ompleted here + then
	of the only ho	of pre=10105 (
	went to George town	TO THE DE	c procedure.
	Intormation was		daiven to both
	patients r/t abort	- / 11 - /	ocation-tetus/ptrights/
	alternative options		
	Lab Corp > Labo	MA/Nurs	e drawlabs
	CDD 1		
	When reviewing M	R-there wa	<u>s</u> patient who
	Livias Rhod needed	to receive F	Sho-50mca was
	airen the same day	as the proc	edure.
	Interviewed.	rit HR sen	ding Per Evals to
	Imags to complete-	Partir was	not sent. (Beth.
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	be a compern	·	
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Abortion Clinic Nursing Document Request

	Turning Feb 18
V	Patient list/register for Lom -> June 17 - Feb 18
X	list of 31 lanising Leischnich merinang agency no.
Χ,	Complaint Log for June Felo Incident Reports for June Felo
	charge 1c -
V	Personnel policies including;
	Policy for control of communicable diseases includes specific to TB.
	Orientation and training of new employees, contract and agency personnel
	☐ CPR policy
	Annual in-service requirements Annual competency for nursing and other personnel performing lab tests
	M Annual competency for hursing and other personner personner personner
	Patient care/nursing policies and procedures including;
20th -	Composition of and meeting minutes for the patient care personnel committee
MIN	JT Patights method of ID
	Instruction for follow up care and transportation—to include counseling, RH type and
	administration of Rhogam Reporting of post procedure complications and follow up
	Cleaning and sterilization of reusable equipment Autockure Training Side
	and electring and stormeration of reasons of
	Infection control program and policies including; — All Both's Swuly of Motor
	Provision for active and effective Infection Control Program
4	Sterilization policies and procedures including;
/	[7] Instructions for loading, operating, cleaning and maintaining sterilizers
	M Instructions for cleaning packaging, storing, labeling and dispensing of sterile supplies
	Records of sterilization cycle and results of biological indicators in testing sterilization
	Cleaning of environmental surfaces contaminated by blood or infectious material
×	Anesthesia policies including;
	X Safety rules to be followed
	Safety training required of personnel
	Preanesthesia, intraoperative and post anesthesia policies and requirements
	Dharmony particles including:
00 V-	Pharmacy services policies including; PRecords of stock supplies and accounting of all items Policies for drug handling, storing, labeling dispensing and administration Cyalle Policies for drug handling, storing, labeling dispensing and administration Cyalle Policies
Hall	Policies for drug handling, storing, labeling dispensing and administration College Charletter
<i>E</i> .	M Kehoting of suverse featuring upon on our Compe
	Storage and security Grace reviewed
	Dromulary - Grach reviewed
	☐ List of available emergency drugs
$ \sim$ \sim \sim	12/11/15 - list 1
V	10/4/10. 1101 PW
V	Trof out-6m > to ER 13/14/15-1ist 6m Return visits & incomplete For Sx > 6m 09/02/2014
1	13/14/15-list lom Return visits & incomplete For Sx > lom 13/14/15-list lom Return visits & incomplete For Sx > lom 15/102/2014 Infections reported > lom
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Fac# 013765

Indiana State Department of Health

Abortion Clinic Human Resources Request Form

0	Prior education,	. 9	competencies
٥	position/title,	. •	current CPR status,
ø	date of hire,	9	most recent evaluation,
•	license/certification,		physical exam/tests,
6	initial orientation,		two step PPD,
ø	in-servicing/education,	٥	Immunizations per facility policy.
6	job description,		
Nursi 1. Cx 2. \(\text{\chi} \) 3. \(\text{\chi} \) 5. \(\text{\chi} \) 6. \(\text{\chi} \) 7. \(\text{\chi} \) 9. \(\text{\chi} \) 10. \(\text{\chi} \)	illes available for review process. ng: Narak RN- JP NA NA	THANK YOU.	per file or have a staff member familiar
Admi	nistration:		
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Personnel files should include:

TAC/CONGERNIC	
TAG/CONCERNS	O. DOCUMENTATION
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	on rest from corporate -
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	Completed HR files - 2 out of 3. Evals not
	done for 2019. Confirmed by \$758 /50
	Issisted other surveyors
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	Facility Name	planned parenthood- Lafayette Date 3/5-3/1/18
		ABORTION CLINIC SIGN IN SHEET
57 58 59	NAME (Print)	TITLE (Print) (Key) Health Center Manager Dir. of Clinical Services VP of Patient Service Dir. of Clinical Operation
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Abortion Clinic: Name/Class	Prior	Hire	Lie/	Orient	1n-	Date: CPR	Last	Compe	Phy Exam	Immun	PPD 2 step	Other.	Jam.
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Indiana State Department of Health Patient/Record Identifier Table

Name of abortion clinic:		·	
Date of survey:			
Type of survey:	Launeis 1	cotes for #16t	
Patient's name	Numbe	r assigned by surveyo	r to
or medical record number	En.	patient's name or edical record number	
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ABORTION CLINIC MEDICAL RECORD REVIEW

C PGD	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#
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Patient identification to incinde:		******		- 3(p						
Name Name of the Name of States of S	V -		/	1		1		√	<u> </u>	
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Procedures for surgical abortion must include preprocedure testing that]		1
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On-site proof of pregnancy as evidenced by a pregnancy	1	.6	· /	1		1.	<i>/</i> :	,	1.	
just, a copy of a pregnancy test or an ultrasound . 2010	√	V	<u> </u>		1				¥/	-
Verification and documentation of gestational age		<u> </u>		1			7	V	- V	
Hematocrit-or hemoglobia	<u> </u>	1		 ``						-
P Literaling	<u> </u>				<u> </u>		<u> </u>	·	<u> </u>	1.7
Completion of the abortion documented by ultrasonography	1	1	/	1	1	No.	· <i>y</i> ř		7.	1.7
or other clinical means	₩.	<u>v</u>	1 4	<u> </u>	 		· •	X	, V	1
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Preanesthesia evaluation within forty-eight (48) hours before a surgical		1 .								ļ
harting	*	1	-	 	 	And 1	``			
History and physical examination report to include:	1,	 	+		+	/	1.	V		17
Vital signs	1	4	+~	+	'	1	***		-	1/
Allergies		1/	1	1	-	7	1	-	/	+-/-
Any significant risk factors	- V	1-/	\ <u> </u>	1-			15	 	1	+ -
The date written	- X-		V	\ <u>\</u>	1-	12	1	1	7	
Appropriate medical history	\v_	- X	1-/	- X	1		1-		1-5	1
Results of a physical examination	_ Y.	- L	14/	- Y	 			+*	 	
Results of any diagnostic studies		17	 	 ¥	12	ally me	100	 /	 	17
Results of any laboratory studies	-	12:	1/	1.4	\ <u>/</u> _	1	-	\ <u>\</u>	· ·	
Any allergies and abnormal drug reactions	1		Y	1		-نرز	15	 " /	1 × /	+ *
Entries related to anesthesia administration	<u> </u>			· ·	 	-	 	V	\ '	- · · ·
Evidence of appropriate informed consent for procedures and treatments as	1	1		1		1		1		
required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)	1	V .		- A		 Y	+	 ``	1-X	1
A report describing techniques, findings, and tissue removed or altered.			- 	 	 	 	- 	<u> </u>	-	
Authentication of entries by the physician or physicians and health care	1/	1.7	1/	1	1		/		V	
workers who treated or cared for the patient.	 '		 * -	 - ~	V	- V		 	1	-
Condition on discharge, disposition of the patient, and time of discharge.		-				 	 	-	1 /	17
Discharge entry to include instructions to the patient or patient's legal		1 /	/	/	1	- ا	ا 🗸	سبسبرا	1	V
representative.	_ <u> </u>	+~		- -~-			 	1		
Copy of the transfer form, if the patient was referred to a bospital of other			1	4	1	1	1	1	1	1 .
facility.	1	1.7	1	1/	1	1/	_/		1	V
Copy of the terminated pregnancy report		→ * -		-	- 	7	- 	17-	╁╀	17:
Copy of any report filed with a state agency or law enforcement agency	1	1		1		i		1	1	
pursuant to a studytory reporting requirement.					-				1.	
Discharge information to include: Signs and symptoms of possible complications	17	17	- '		1	17.	17	17	1	1
Activities allowed and to be avoided	17	i,×	100	T.		1			1	
Activities anower and to be avoided Activities anower and to be avoided		- ·		- 	<u> </u>	-	1 .	- - <u></u> -	: .	
tollower	4,400	سبرز	سبن ا	المرز ا	1		1	W.	100%	
Clinic emergency phone numbers available on a twenty-				-	THE PERSON NAMED IN COLUMN TWO	-ز			1/	
four (24) hours basis	14	1/	1	1	1	V	1	1	1	1
Follow-up appointment, it indicated		16	10	1/_	1/8	10	17	1	1	1
Counsuling reparding Rh (yping	1	17			7	7				
Administration of Rh Immune globulin, if indicated—	1									•
unless patient signs a waiver or other arrangements for	1]			1		i		
administration are documented		<u> </u>	1			1	_1			
Conscious sedation						1			-	
Frequent monitoring for verbal responses										
Monitoring for respiratory, cardiovascular and	1	1			-	1	.1			1
neurological effects of the drugs being used		<u> </u>	<u> </u>		1				<u> </u>	
Postanesthetic evaluation for proper anesthesia recovery before discharge				1						
Form 56108 - Certification of Provision of Perinatal Hospice Information	1		400	-		1	1		_	
(Time of Abortion Consent Decision)		-					1		4	
Form 56113 - Certification of Provision of Perinatal Flospice Information										
Form 56114 - Disposition of Aborted Fotos										1
Form 56115 - Available Counseling after an Abortion			T					``		

\$ = aid not follow-up

09/09/2016 VS = BPONLY

ABORTION CLINIC MEDICAL RECORD REVIEW

·	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT ID#	PT JD#	PT ID#	PT ID#
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Addross	1	/	✓		1	<u> </u>	/			<u> </u>
Procedures for surgical abortion must include preprocedure testing that	ŀ		t	ŀ					i	
includes:	 	†		· 	1			 	 	
On-site proof of pregnancy as evidenced by a pregnancy				_/	/	1/	/		I	l
test, a copy of a pregnancy test or an ultrasound	 '		1	 × –	 // 	+-/-	4/		 	
Verification and documentation of gestational age	 		-	12	1/	+/_	-	 	 	
Hematocrit or hemoglobin	 		 	1-	 	12		 		+-
Rh typing	+ ,	 	 	 	╁──	1	· · · · · ·	 	+	+
Completion of the abortion documented by ultrasonography	1/		1 /	⊹	/	15/	/	ł		1
or other clinical means Provision of follow-up examination and services	╁┷	 		 ` 	╅	+-	·			
Provision of follow-up examination and services Preanesthesia evaluation within forty-eight (48) hours before a surgical	 	 	 	 	 	1		1	1	1
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abonion History and physical examination report to include:	1	t	T	1	1	1 /				T
Vital signs	1/	1/	/	1/	1.7	1/	.			T
Allergies	1.7	ブ	17.	1	17	17	1/	1	1	1
Any significant risk factors	1		1		1/			1		1
The date written	1./	フ	1	1/	17	1/	1			
Appropriate medical history	1/	17.				1/				T
Results of a physical examination		+/	1./	17.			1			T
Results of any diagnostic studies			17	1			1			
Results of any haboratory studies	1.7	17		V	17	1/	V			
Any allergies and abnormal drug reactions	15	17		17	1./		1	1		T
Entries related to anesthesia administration	1		—	1						T
Evidence of appropriate informed consent for procedures and treatments as	1		<u> </u>		 	1,		1		T
required by IC 16-34-2-1.1. State form 55320 (6-13) and 55321 (6-13)	V		/	-	I		✓ .	l		<u></u>
A report describing techniques, findings, and tissue removed or altered.			1	1	T					T
Authentication of entries by the physician or physicians and health care	17		1 .	1						1
workers who treated or cared for the patient.	✓					V		<u> </u>		
Condition on discharge, disposition of the patient, and time of discharge.				1				<u> </u>		
Discharge entry to include instructions to the patient or patient's legal	17	/		1			/		1	1
representative.	√		<u> </u>	1			1			
Copy of the transfer form, if the patient was referred to a hospital or other	1				1	1	1	,	1	1
facility.		1	<u> </u>	1		<u> </u>	↓ _	ļ		
Copy of the terminated pregnancy report.	1	_		<u> </u>		V	1	ļ		
Copy of any report filed with a state-agency or law enforcement agency		1	1				i	ł		
pursuant to a statutory reporting requirement.		↓	<u> </u>							——
Discharge information to include:		1	-			+	 	 		+-
Signs and symptoms of possible complications	~	\ <u>\</u>	14/	1	14		 			+
Activities allowed and to be avoided	<u> </u>		1-		/	1.	- V	 		┿~
Hygienic and other postdischarge procedures to be	1/		/	1/	/		/			
followed		1	1~	14-			1	L		
Clinic emergency phone numbers available on a twenty- four (24) hours basis	1/		1	/		1//		Τ.		1
Follow-up appointment, if indicated	15/		1.	+*/	-	1./	+-/-	 		+
Counseling regarding Rh typing	+	Y	Y	 	 v	 ¥	-	 	-	+
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unless patient signs a waiver or other arrangements for		f	1				1			
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Form 56108 - Certification of Provision of Perinated Hospice Information	1	T].	1	T		T	1	1	T
(Time of Abortion Consent Decision)		1	<u>†</u>				<u></u>			
Form 56113 - Certification of Provision of Perinatal Hospico Information										
Form 56114 - Disposition of Aborted Fetus										
Form 56115 - Available Counseling after an Abortion	1		1					1	1	T

AAB failed N/V p pill - Nescan to Georgetown for surgical AB 1000 Pd.

Op/109/2016

My Unable to reify parent 5 child - signature yes

* abfailed 1001d - hereined pill . rescan 10001d - appt made en Merrelluille Surgeral 43 Alb failed. 8060 followup reseau failed 1000 Augicae AB on s@ goigetown

ABORTION CLINIC NURSING TOUR

Abortion Clinic Nursing Document Request

	Lucy Trop JUIT- Feb 7018 X Trest 6m-ER
V	Patient list/register for June 2017 - Feb 2018 List of all Nursing Personnel including agency for
,X	List of all Nursing Personnel including agency for (017)
\sim	Complaint Log for Tipe of Table 2000
V /	incident Reports for Fine February
✓ .	Critical Tolling including:
. /	□ Policy for control of communicable diseases includes specific to TB
James (☐ Orientation and training of new employees, contract and agency personnel
100° 901	☐ CPR policy
Mary Mary	☐ Annual in-service requirements
TUN	☐ Annual competency for nursing and other personnel performing lab tests
1.	
	Patient care/nursing policies and procedures including;
	Composition of and meeting minutes for the patient care personnel committee
	Reliable method of ID
	☑ Instruction for follow up care and transportation—to include counseling, RH type and
	administration of Rhogam
	区 Reporting of post procedure complications and follow up
	Cleaning and sterilization of reusable equipment
	Infection control program and policies including;
	Composition and meeting minutes of infection control committee
	☑ Provision for active and effective Infection Control Program
~	Sterilization policies and procedures including;
^	☐ Stermization policies and procedures including, ☐ Instructions for loading, operating, cleaning and maintaining sterilizers
	✓ Instructions for cleaning packaging, storing, labeling and dispensing of sterile supplies
	Records of sterilization cycle and results of biological indicators in testing sterilization
	Cleaning of environmental surfaces contaminated by blood or infectious material
	•
X	Anesthesia policies including;
	Safety rules to be followed
	☐ Safety training required of personnel
	Preanesthesia, intraoperative and post anesthesia policies and requirements
(Pharmacy services policies including;
7	☐ Records of stock supplies and accounting of all items
menco 7	☐ Policies for drug handling, storing, labeling dispensing and administration
//m_ /	☐ Reporting of adverse reaction and medical errors
~\	☐ Storage and security
	Formulary
. 1	☐ List of available emergency drugs



200 South Meridian Street, Suite 400, Indianapolis, IN 46225 Mailing Address: P.O. Box 397, Indianapolis, IN 46206-0397 p: 317.637.4343 · f: 317.637.4344 www.pplnk.org

Planned Parenthood of Indlana and Kentucky

March 30, 2018

To Whom It May Concern:

Please see the enclosed Plan of Correction as a response to the Statement of Deficiencies report received March 28, 2018 for Planned Parenthood of Indiana and Kentucky's Lafayette Facility (#160137651).

Our contact for questions on these documents is

Kind Regards,

, Vice President of Patient Services

Eric J. Holcomb

Kristina Box, MD, FACOG State Heats Complianment

Indiana State

March 26, 2018-

4A-07

Planned Parenthood Of Indiana-Merrillville 200 S. Meridian Street, Suite 400 Indianapolis, IN 46225

NOTICE OF NON-COMPLIANCE **FACILITY# 170137651**

Dear.

Enclosed please find the State Form "Statement of Deficiencies and Plan of Correction" report, listing each deficiency noted during the State Licensure survey conducted on March 7, 2018 at your facility. Your Plan of Correction on the State Form must be preceded by the appropriate ID prefix tag (TAG NUMBER).

Be sure that each individual Plan of Correction answers the following questions:

- How are you going to correct the deficiency? If already corrected, include the steps taken and 1. the date of correction.
- How are you going to prevent the deficiency from recurring in the future? 2.
- Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? 3.
- By what date are you going to have the deficiency corrected? 4.
 - You must provide a specific date the deficiency will be or has been corrected (month, a. day, and year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the Notice of Noncompliance.
 - If the nature of the deficiency precludes completion within the b. above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phases.
- * Please assure that the survey form "Statement of Deficiencies and Plan of Correction" is signed on the first page under "Laboratory Director's or Provider/Supplier Representative's Signature".



Page 2 March 26, 2018

Based on these findings, the Department has determined that Planned Parenthood Of Indiana And Kentucky, Inc -, located at 964 Mezzanine Dr, Lafayette, Indiana is in violation of Indiana Code 410 IAC 15-2 and accompanying regulations.

This will be the only Notice of Non-compliance issued by the Department. Failure to respond to this Notice within fifteen (15) days of the date of this letter may result in legal actions against this facility pursuant to Indiana Code 4-21.5 and 410 IAC 15-2. Such actions include, but are not limited to, a complaint for civil penalties of up to \$10,000.00 per day, per violation, injunctive relief and criminal sanctions. State law requires that this document becomes public information ten (10) days after you receive it.

The Department provides an Internal Dispute Resolution (IDR) process by which facilities may contest allegations contained in the Statement of Deficiencies. Planned Parenthood Of Indiana And Kentucky, Inc - may petition the Division Director of Acute Care to implement the IDR procedure in writing. The petition must include the following:

1. Tag Number disputed;

2, Statute or regulation section;

3. A statement as to the exact nature of the dispute and the reasons for the dispute; and

4. A statement as to what result the facility is seeking (example deleted, tag code changed, tag climinated).

In addition, the petition must be accompanied by any and all evidence and/or information that the facility believes is appropriate. This evidence or information may include, but be limited to, agency records, policies, documents, affidavits and other items that will aid the IDR Panel in reviewing the contested deficiencies. The petition must also be accompanied by a completed IDR Tracking Record, which is enclosed.

Sincerely,

JENNIFER HEMBREE RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

innifes He Sucker

317/232-3095

Enclosures

REGULATORY SERVICES INFORMAL DISPUTE RESOLUTION (IDR) RECORD

State Form 50058 (R/2-01)

*The facility requesting IDR must complete the <u>unshaded</u> portion of this page ONLY.

Provider #: Date Survey Completed Date Facility Requesting IDR: Phone: Pho
Date Facility Requesting IDR: Phone: Phone: Diffied "Informal Dispute Resolution (IDR) Instruction
Phone: cititled "Informal Dispute Resolution (IDR) Instruction ad below. In your Plan of Correction (POC), provi the for each Tag. You must state specifically what upport for your position is located in supporting recon- tiveter. Only documents that are pertinent and DO NOT submit excessive numbers of documents
ntitled "Informal Dispute Resolution (IDR) Instruction and below. In your Plan of Correction (POC), provide for each Tag. You must state specifically what upport for your position is located in supporting reconcern. Only documents that are pertinent and DO NOT submit excessive numbers of documents.
ed below. In your Plan of Correction (POC), provide for each Tag. You must state specifically what upport for your position is located in supporting recificate. Only documents that are pertinent and DO-NOT submit excessive numbers of documents.
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ed below. In your Plan of Correction (POC), provide for each Tag. You must state specifically what upport for your position is located in supporting recificate. Only documents that are pertinent and DO-NOT submit excessive numbers of documents.
THIS SECTION FOR OFFICE USE ONLY:
4 ****
RESOLUTION
No Change Example(s) Deleted Tag/Code Changed Tag Deleted
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No Change Example(s) Deleted Tag/Code Changed Tag Deleted

144 Facility failed to provide an annual evaluation of 2 out of 3 eligble employees	Parenthood of Indiana and Kentucky, se to ISDH Abortion Licensing Review cresults received March 28, 2018
PPINK to develop more detailed policy on employee evaluations, policy to include timeline All employees to have completed annual evluation by July Health Center 1, 2018 Human Resource Team and Evaluation by July Health Center Manager	Lafayette Facility #160137651 onducted March 7, 2018 Corrective Action
Human Resources Team and Health Center Manager	Responsibility
Policy to be completed by April 30, 2018; evaulations to be completed by June 30, 2018	Date of Correction

· ,

144	Tag #	Planned Respon- Survey
144 Facility failed to provide an annual exaluation of 2 out of 3 eligble employees	Problem Identified	Planned Parenthood of Indiana and Kentucky, Lafayette Facility #160137651 Response to ISDH Abortion Licensing Review conducted March 7, 2018 Survey results received March 28, 2018
PPINK to develop more detailed policy on employee Human Resou evaluations, policy to include timeline All employees to have completed annual eviuation by July Health Center 1, 2018	Corrective Action	e Facility #160137651 March 7, 2018
Human Resources Team and Health Center Manager	Responsibility	
Policy to be completed by April 30, 2018; evaulations to be completed by June 30, 2018		

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	State Department of	Health						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	(XS) MÜLÜNG:		(X3) DATE SURVEY COMPLETED		
		013765	B. WING_		03/	07/2018		
NAME OF PROVIDER OR SUPPLIER STREET ADD				DRESS, CITY, STATE, ZIP CODE				
PLANNED PARENTHOOD OF INDIANA AND KE 984 MEZZANINE DR LAFAYETTE, IN 47905								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL- SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE JE APPROPRIATE	(XS) COMPLETE DATE		
T 000	INITIAL COMMENT	7S	T:000					
	This visit was for a	State licensure survey.						
	Facility Number: 01	13765	ma de la francisco	ļ				
:	Dates of Survey: 3	1/5/2018 to 3/7/2018				:		
	QA; 3/15/2018					·		
Ť 144	410 IAC 26-8-1 PEI RECORDS	RSONNEL POLÍCIES AND	T 144	The second secon		· ·		
	410 IAC 26-8-1(c)(1	r)						
	reporting responsib annual performance eva	do the following: ent job descriptions with illities for all personnel and aluations, based on the job h employee and contract a						
	personnel.					A CANADA		
				**Constitution of the constitution of the cons				
5				The state of the s	ı			
	Based on documen	net as evidenced by; t review and interview the vide an annual evaluation of ployees.	of:2					
	Employee Handboo Performance Evalui receive an annual p their immediate sup	115 Planned Parenthood ok indicated on page 16 un ations that employees may erformance evaluation by ervisor and may be asked luation. Evaluations are k	to					

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6)-DATE

Indiana :	State Department of	Health	DAYON ARI SI TUTTI	r governionon	(X3) DATE SURVEY	1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
						Ì
		013765	B. WING		03/07/2018	
NAME OF I		STREET Ä	DRESS, CITY, S	STATE, ZIP CODE		
PLANNE	D PARENTHOOD OF		ZANINE DR TE, IN 4790	2		-
		TEMENT OF DEFICIENCIES	D.	PROVIDER'S PLAN OF CORRECT	ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX.	(BACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE COMPLE	ere
T 144	Continued From pa	ge 1	T 144	,		
	in the employee's personnel file.			. •	/ I :	
ļ	2. Review of P50:	Health Care Manager's job				
	description indicate	s under Essential Functions:		_	1	
ļ	improvement docur	ry and performance nents independently and		·		
	provides indicated i	management follow-up.			-	
	3、Review of P50 a	ınd P52, Health Care Assistahl			E-	
	personnel files lack evaluation complete	ed documentation of an			1	,
					ļ	
	 4. Interview with Pt Clinical Services or 	50 and P58; Director of n 03/06/18 at 3:20 pm		·		
	confirmed lack of e	valuations in P50's and P52's			77	
	personnel file and t	hey were not done.		,		
	<u> </u>				. 11.1	
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200 South Meridian Street, Suite 400, Indianapolis, IN 46225
Mailing Address: P.O. Box 397, Indianapolis, IN 46206-0397
p: 317.637.4343 · f: 317.637.4344
www.ppink.org

Planned Parenthood of Indiana and Kentucky

March 30, 2018

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L, Vice President of Patient Services

Erio J. Holtoinb Governor

Kristina Box, MD, FACOG State Heads Control account



March 26, 2018

4A-07

Planned Parenthood Of Indiana-Merrillville 200 S. Meridian Street, Suite 400 Indianapolis, IN 46225

NOTICE OF NON-COMPLIANCE FACILITY# 170137651

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- * Please assure that the survey form "Statement of Deficiencies and Plan of Correction" is signed on the first page under "Laboratory Director's or Provider/Supplier Representative's Signature".



Page 2 March 26, 2018

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- Statute or regulation section;
- 3. A statement as to the exact nature of the dispute and the reasons for the dispute; and
- 4. A statement as to what result the facility is seeking (example deleted, tag code changed, tag eliminated).

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Sincerely,

JENNIFER HEMBREE RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

unifes He Sucker

317/232-3095

Enclosures

REGULATORY SERVICES INFORMAL DISPUTE RESOLUTION (IDR) RECORD

State Form 50058 (R/2-01)

	Provider #: Date Survey Completed Date Facility Requesting IDR: Phone:
	Date Facility Requesting IDR:
	Phone:
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nity and scope) that is dispused in the dispused in the dispused in the 2567 and where a labeled "Attachment As."	entitled "Informal Dispute Resolution (IDR) Instruction (IDR) Inst
HECK ONE ONLY:	THIS SECTION FOR OFFICE USE ONLY:
	RESOLUTION
R REVIEW	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
TO FACE	No Change: Example(s) Deleted Tag/Code Changed- Tag Deleted
	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
	No Change Example(s) Deleted Tag/Code Changed Tag Deleted
	IDR COMPLETED DATE

	,			
			•	

WOMEN'S MED GROUP PROFESSIONAL CORPORATION 1201 N. ARLINGTON AVENUE INDIANAPOLIS, INDIANA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011128	B, WING		04/04/2018
	ROVIDER OR SUPPLIER MED GROUP PROFESS	1201 N.A	DDRESS, CITY, STATE RLINGTON AVE POLIS, IN 46219	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
т 000	INITIAL COMMENTS		T 000		
	This visit was for a sta	128			
	Survey Date: 04-02-	2018 to 04-04-2018			
T 098	410 IAC 26-6-1 QUA IMPROVEMENT	LITY ASSESSMENT AND	T 098		
	410 IAC 26-6-1(a)(2)				
	plan of implementation limited to, the following: (2) All functions, in the following: (A) Discharge. (B) Transfer. (C) Infection or	ncluding, but not limited to,			
	facility failed to include emergencies in its quantum facility failed to include the facility	review and interview, the de response to patient			

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		011128	B, WING		. 04	/04/2018
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STAT	'E, ZIP CODE		
WOMEN'S	MED GROUP PROFESS	MANAL CAPBADAT	RLINGTON AVE POLIS, IN 46218			
(X4) ID PREFIX TAG	IFACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCEO TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETE DATE
T 098	Continued From page	e 1	T 098			
	Review of the clinicalendar year 2017 in response to patient expense.	ndicated it did not include		·		
	In interview on 04 employee #A1, Assis above and no other of prior to exit.	-04-2018 at 5:15 pm, tant Director, confirmed the locumentation was provided				
T 134	410 IAC 26-7-2 MED	ICAL RECORDS	T 134		~	
	410 IAC 26-7-2(c)					
	document and contained following: (1) Patient identification (2) Appropriate material (3) Results of the (A) A physical (B) Diagnostical (If performed).	cation. edical history. following: examination. or laboratory studies, or both and abnormal drug reactions.				
*	(6) Evidence of a for procedures and t 16-34-2-1.1.	ppropriate informed consent reatments as required by IC ribing techniques, findings,				
	and tissue removed (8) Authentication or physicians and he treated or	or altered. n of entries by the physician paith care workers who				
	patient, and time of	discharge, disposition of the				

		alth	ndiana State Department of Health (X3) DATE SURVEY (X3) DATE SURVEY					
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET			
		011128	B, WING		04/04/	2018		
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STAT	E, ZIP CODE				
	MED GROUP PROFESS	TARADOGAN IARAP	RLINGTON AVE					
MOREM		15.000	POLIS, IN 46219	PROVIDER'S PLAN OF CORRECTIO	N.	(X5)		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE DATE		
TAG	REGULATORY OR L	.SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)				
T 134	Continued From page	2	T 134					
1 104	(11) A copy of the							
	(A) The transfe	r form if the patlent was						
	referred to a hospital	or other facility.						
	(B) The termina with the department.	ated pregnancy report filed						
	(12) Any report file	ed with a state agency or law						
		pursuant to a statutory						
	reporting requirement.							
					-			
		•						
	This RULE is not me	t as evidenced by:			1			
	Based on document	review and interview the e a copy of the terminated			į			
	pregnancy report was	s in the medical record (MR)			Action			
	in 25 of 25 medical re	ecords reviewed (1, 2, 3, 4,						
	5, 6, 7, 8, 9, 10, 11, 1 20, 21, 22, 23, 24 an	2, 13, 14, 15, 16, 17, 18, 19, d 25).						
	201 2 11 mm 201 2 7 MI	1 -						
	•							
	Findings Include:		,					
		4 2 2 4 5 6 7 8 2 40						
	1. Review of patients 11. 12. 13. 14. 15. 16	; 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 5, 17, 18, 19, 20, 21, 22, 23,						
	24 and 25's medical	records lacked						
	documentation of a to state form 56114.	erminated pregancy report						
	2. Interview on 4/4/2	018, at approximately 12:30		1				
	pm with N1 (Register Director) confirmed f	acility had not included a						
	state form 56114 in t	he medical records.						
	4014000015	CONNEL DOLLOIDO AND	T 140					
T 140) 410 IAC 26-8-1 PER RECORDS	SONNEL POLICIES AND						
						•		
	410 IAC 26-8-1(a)(2))						

Indiana State Department of Health			1.	COMMETTING E C	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1				LETED
WAR ECUIA C	, was a more roll.			, 2011211101,			
		011128	1	B. WING		04/	04/2018
MAME OF D	ROVIDER OR SUPPLIER	Sĭ	REET ADDRE	SS, CITY, STATE	E, ZIP GODE		
		. 45		NGTON AVE		1	
WOMEN'S	MED GROUP PROFESS	MANAL CARBARAT		IS, IN 46219			·
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
T 140	Continued From page	ə 3		T 140		٠	
	accurate personnel n Personnel records st (2) include person (A) education; (B) experience (C) date of em (D) a copy of c required; (E) evidence of educational and train (F) health record to post offer and sub	al data to include: ployment; purrent license when f participation in job-relate ling activities; and ords of employees that rela sequent: examinations;	d				
	facility failed to ensu (S1, and S5) person reviewed. Finding Include: 1. Review of facility 3/1/2018, indicated contains the followin and social security in hepatitis vaccination and information rela	review and interview, the re physical examination fo nel files of 6 personnel file policy, Safety, revised the following, the recording on each employee, namumber, a copy of the a series status including dative to the employee's abil	s ne ntes				
	to receive the vaccinimmunizations and amployee accidents	nation, copies of annual TB testing or exam, a copy reports, a copy of all ination results, medical tes	/ of				

Indiana State Department of Health			(Va) Littrial F	CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ		COMPLETED	
AND PLAN (OF CORRECTION	PERMINATION OF COMMENT	A. BUILDING: _			
		011128	B. WNG		04/04/2018	
NAME OF D	ROVIDER OR SUPPLIER	STREETA	DORESS, CITY, STAT	E, ZIP CODE		
		1201 N A	RLINGTON AVE			
WOMEN'S	MED GROUP PROFESS	1,120/19 4594	POLIS, IN 46219	PROVIDER'S PLAN OF CORRECTK	ON (X6)	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. LSC [DENTIFYING INFORMATION]	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
T 140	Continued From page	3 4	T 140			
	the healthcare profes copy of information p professional, records monitoring, records of and records of any of intervention. 2. Review of personr following, S1 (Medica (Licensed Practical N of Physical Examinal	al Assistant) and S5 Jurse), lacked documentation tion. 018, at approximately 9:50 ered Nurse, Assistant				
T 168	RECORDS 410 IAC 26-8-3(b) (b) The clinic shall el resuscitation (CPR) with current standard for all health care wo	nsure cardiopulmonary competence in accordance ds of practice and clinic policy orkers including contract and the provide direct patient care.	T 168			
	facility falled to follow cardiopulmonary res competence in acco	review and interview, the wits policy to ensure suscitation (CPR) ordance with clinic policy for 1 ontial files reviewed and 2 of 6				

Indiana S	<u>tate Department of He</u>	alth		0.60	AN ASSOCIATION	(X3) DATE S	IRVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	- 1		CONSTRUCTION	COMPLE	
AND PLAN C	FCORRECTION	(OCIATII IOMIOH MONIOCA)		A, BUILDING:	,		
		011128		B. WING		04/0	4/2018
		eri	COLUCT ADDD	ESS, CITY, STAT	5 ZIP CONS		
NAME OF PR	ROVIDER OR SUPPLIER						į
WOMEN'S	MED GROUP PROFESS	SIAMAL CARPARAT		NGTON AVE LIS, IN 46219			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETE DATE
T 168	8 Continued From page 5		-	T 168			
Т 206	Safety Handbook, ap the Safety Manager remployee's training in life safety]. Further in Indicated the Safety I physicians maintain c ACLS [advanced card. 2. Review of 2 physifile MD#2, Gynecolog ACLS that expired 3/ facility policy. 3. Review of employ Medical Assistant, an Nurse, lacked documentence per facility policy. 3. In Interview on 04 5:15 pm, employee # confirmed all the abod documentation was performed to IAC 26-11-1 INF PROGRAM 410 IAC 26-11-1(a)(1) (a) The clinic must depend to IAC 26-11-1(a)(1) Provide a safety.	cian credential files indicating ist, had documentation of 20/2016, not current per ree files indicated file S1, and S5, Licensed Practical tentation of CPR lity policy. 1-04-2018 at approximately fA1, Assistant Director, over and no other provided prior to exit. ECTION CONTROL 1) o the following: and healthful environmention exposure and risk to the	d sic ted f	Т 206			
	(C) Persons w	rho accompany patients.					

P3\$R11

Indiana State Department of Health		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMPLETED
WIND STAIN (OF CORRECTION		W. BOILDING; _		
		011128	B, WING		04/04/2018
		STOCKT AL	DRESS, CITY, STA	FE. ZIP CODE	
	ROVIDER OR SUPPLIER	1201 N A	RLINGTON AVE	•	
WOMEN'S	MED GROUP PROFESS	STANTAL CODDODAT	OLIS, IN 46216	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
Т 206	Continued From page	∍6	T 206		,
	interview, the facility healthful environmen	of as evidenced by: review, observation and failed to ensure a safe and t that minimizes infection patients in three instances.			
	Findings include:				
	Review of Hemoculandicated the following with alcohol or a mild	g, the cover may be cleaned		·	
	2:27 pm with N1 (Red Director) the following	2/2018, at approximately gistered Nurse, Assistant g was observed, a cardboard colored droplets taped on			
	pm. with N1, confirm	018, at approximately 2:47 ed there was brownish cardboard note taped to		1	
	3:15 pm, with N1 (Re Director) the followin dryer in back of store sticky lines of materi glue) which could no and debris under she	2/2018, at approximately egistered Nurse, Assistant g was observed washer and age room. Floor of room with al (appears to be old flooring of the properly cleaned. Dirt belies with sterile supplies tology brushes and cotton tip in the shelves.			
	pm with N1, confirmed bought into storage machines, the floor was	018, at approximately 3:15 ed the dirty laundry was room and loaded into was covered in sticky lines were stored on shelves.			

P38R11

STATEMENT	Indiana State Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011128	B. WNG		04/04/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STAT	E, ZIP CODE	
WOMEN'S	MED GROUP PROFESS	HANKE CARRARAT	ARLINGTON AVE APOLIS, IN 46219		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETE
T 206	Continued From page	9 7	T 206		
	6. Review of facility policy, Women's Med, revised 12/6/2017, indicated the following, Inventory Management, ensures items do not expire before being used. 7. On observation 4/2/2018, at approximately 3:27 pm, with N1 (Registered Nurse, Assistant Director) the following was observed 1 box of 23G needles expired in 2001-08, containing 22 needles.				
	8. Interview on 4/2/20 pm with N1, confirme	018, at approximately 3:27 at the expired needles.		•	
ፐ 234	410 IAC 26-11-2 INF PROGRAM	ECTION CONTROL	T 234	,	
	410 IAC 26-11-2(a)				
,	be provided, within the offered, in accordance of practice or manufactures	ulpment and supplies must ne scope of the service ce with acceptable standards acturer's recommendations laws and rules (to include			
	410 IAC 1-4, UNIVER	aa (160auuu19).			
	observation, the faci	review, Interview and lity failed to ensure facility regarding cleaning of			
	, manage manage				

Indiana S	tate Department of He	alth	1	a cultural lattors	(X3) DATE SU	RIÆY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	CONSTRUCTION	COMPLETED	
AND PLAN C	F CORRECTION	INCIA! FLOW FOR MONDERY	A. BUILDING:			ļ
		011128	B. WING	**	04/04	/2018
	with an object the	STREET A	DDRESS, CITY, STAT	TE, ZIP GODE		
	ROVIDER OR SUPPLIER	1201 N /	ARLINGTON AVE	•		
WOMEN'S	MED GROUP PROFESS	TARAGRANA ENIME	APOLIS, IN 46219			İ
		3112111		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE DATE
PREFIX TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	NAIE	DAIL
T 234	Continued From page	∍ 8	T 234			
,			1		-	
	1. Review of facility p 3/1/2017, indicated the	olicy, Salety, revised				
	instruments in a corre	matic cleaner/lubricant				
	/such as Metri Clean) for 5 minutes following the				
	manufacturer's direct	lons for preparation and				
	use.					
	2. Observation on 4/2	2/2018, at approximately				
	4:25 pm with N1 (Re	egistered Nurse, Assistant				
	Director) the following	g was observed. Metri Clean]			
	2 in instrument proce Metri Clean 2 label in	essing area. Review of the		·	ļ	
	enzymatic cleaner.	ICIORISCI IL MAS HOLDI			1	
	GIZYITERIO GIOGNOS	•				
	3. Interview with on 4	1/2/2018, at approximately				
	4:25 pm, with N2 (Me	edical Assistant) confirmed				
	Metri Clean 2 was us	sed to clean instruments.	•			
		ada at approximately 4:34				
	4. Interview on 4/2/20	018, at approximately 4:34 ed Metri Clean 2 instrument				
	cleaner was not enz					
	ONDERIOR WAS HOLDED	· · · · · · · · · · · · · · · · · · ·				
T 322	410 IAC 26-16-1 PH	ARMECELITICAL	T 322			•
1 322	SERVICES	. u 11,,440 () or im		·		
	410 IAC 26-16-1(3)(/	A)				
			-			,
	The clinic must provi	ide drugs and biologicals in a				
	sate and effective me	anner in accordance with al practice. The clinic must			1	
	have the following:	at htaotion. The outlie mast				
	(3) Written policie	es and procedures			;	
	developed, impleme	nted, maintained, and made	, ,			
	avallable to	•				
1	personnel, includ	ing, but not limited to, the				
	following:	•				
	(A) Drug:					
	(i) handling					
	(ii) storing;					

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Indiana State Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE COMP	SURVEY	
		011128	B. WING		04	/04/2018
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STAT	E, ZIP CODE		
	MED GROUP PROFESS	NANAL COBBODAT	RLINGTON AVE POLIS, IN 46219			
(X4) ID PREFIX TAG	I JEACH DESICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X6) COMPLETE DATE
T 322	Continued From page (iii) labeling (iv) dispens	, ,	Т 322			
	(v) administ established clinic pol standards of practice	tration according to icles and acceptable			•	
				,		
	This RULE is not me Based on document interview the facility related to medication	review, observation and failed to implement policy				
	Findings include:			·		
	12/7/2017, indicated member removes contained patients immediately supervisor. Act first, unsafe conditions in laboratory reagents, equipment, etc The all nursing staff admistandards of care in administering and hundiscards all drugs month.	policy, Medical, revised I the following, every staff onditions that are unsafe to and then notifies their communicate second. Such clude: expired drugs or improper staff actions, faulty e Head Nurse oversees that ere to best practices and the handling, packaging, anding out of medication. that will expire in the coming				
The state of the s	3:27 pm, in the med (Registered Nurse, following was obser 5mg/mi, 10 mi, 2 ex 12/2017, not include marked needles wa contained blue pape	/2/2018, at approximately Ilication room, with N1 Assistant Director) the ved. 4 vials of diazepam pired 9/2017, and 2 expired ed in count. Inside a box s a plastic bag which er taped shut which contained in 80 mg/2ml, expired				

Indiana S	tate Department of He	alth <u> </u>			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY GOMPLETED
		011128	B. WING		04/04/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
	MED GROUP PROFESS	HONAL CORPORAT	RLINGTON AVE POLIS, IN 4621	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
T 322	Continued From page	10	T 322		
	3/1/2015.				-
	3. Interview on 4/2/20 pm, with N1 confirmed	18, at approximately 3:47 d the above.		,	
T 404	410 IAC 26-17-3 PHY PLANT,MAINT.,EQUI		T 404		
	410 IAC 26-17-3(2)				
	overall clinic environm maintained in such a well-being of patients	visitors; or			
	review, the facility fail equipment to use a co	t as evidenced by:			
	Findings include:				
	the presence of emple	erved in the product of g area a chemical,			The second secon
	2. In interview on the	above date and time,			

Indiana S	tate Department of He	alth			/
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED
		011128	B. WNG		04/04/2018
			DEFINE OF A CTATE	- 7/D 40DC	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	z, ZIP CODE	
UPOMENTO	MED GROUP PROFESS	TOMAL CORPORAT	ARLINGTON AVE		
AACINEIA O	MED GROOT TROTEGO	INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION SHOULD	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
TAG	(LCGL) HOIL OIL	,	"	DEF[CIENCY)	·
			Т 404		
T 404	Continued From page	11	1 404		
	employee #A1 indicat	ed the chemical was used			
	when processing proc				
	·				
		l on the bottle of MetriClean			
	2, a caustic chemical,	indicated there were			
	manufacturer's instru	ctions which indicated First			
		- Flush Immediately with			
	water for 20-30 minut	es.			
	4 Davidson of the OOL	-IA (Occupational and Safety			
	4. Review of the Col) hazard communication			
	program indicated in	general standard 1910.151]		
	when necessary, facil	lities for drenching or	1		
	flushing the eves sha	Il be provided within the			
	work area for immedia	ate emergency use. In	1 . 1		
	applying these general	al terms, OSHA would			
	consider the guideline	es set by such sources as			
	American National St	andards Institute (ANSI)			
	Z358.1 -1998, Emerg	ency Eyewash and Shower			
•	Equipment, which ind	icated in section 7.4.4, that]		
	eyewash facilities are	to be located to require no			
		s to reach but where a			
	strong acid or a causi	lic chemical is used, the unit			
	snould be immediate	y adjacent to the hazard.			
	5 On the above stat	ed date, time, place, and			
	nresence of employe	e #A1, It was observed there			
	was no evewash facil	ity immediately adjacent to			
	the area where the ca	austic chemical was used.			
	6. On 04-02-2018 at	approximately 4:40 pm, in			
	the presence of empl	oyee #A1, Assistant			
	Director, it was obser	ved in Operating Room 1		•	
		al outlet on a wall which had	[
	a broken plug recepte	acle. This posed an			
•		electrical plug was not			-
	properly seated in the	e receptacie.		•	
	7 0 04 00 0040 -4	approximately 4:40 pm in	. [
		approximately 4:40 pm, in oyee,#A1, it was observed			
	l me bresence of empl	Uyee,#MI, IL Was UDSelved	1		<u> </u>

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	,	011128	B, WING		04/04/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, STA	ATE, ZIP CODE		
		1201 N A	RLINGTON AVE	I.		
WOMEN'S	MED GROUP PROFESS	IONAL CORPORAT INDIANA	POLIS, IN 4621	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE COMPLETE	
T 404	Continued From page	12	T 404			
	in Operating Room 1 an alcohol-based han	on another wall, there was d sanitizer (ABHS) on the lectrical outlet. This posed mmable alcohol in the or dropped into the				
	i					
					,	
			THE PROPERTY.			
		. •		:		
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Indiana State Department of Health

Indiana State Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING_ 04/04/2018 011128 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) T 000 INITIAL COMMENTS T 000 This visit was for a state licensure survey. Facility Number: 011128 Survey Date: 04-02-2018 to 04-04-2018 QA: 4/12/18 6/12/2018 Amended State Form. Tag T0134 deleted. Wrong form title cited. Requirement for form 56114 was enjoined by federal injunction at time of survey. T 098 410 IAC 26-6-1 QUALITY ASSESSMENT AND T 098 5/24/18 **IMPROVEMENT** 410 IAC 26-6-1(a)(2) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including, but not limited to, the following: (A) Discharge. (B) Transfer. (C) Infection control. (D) Response to patient emergencies. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to include response to patient emergencies in its quality assurance and performance improvement program (QAPI) for Indiana State Department of Health

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

07/10/18

P3SR11

TITLE

Indiana State Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: _____ B. WING 04/04/2018 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 098 T 098 Continued From page 1 calendar year 2017. Findings include: 1. Review of the clinic's QAPI program for calendar year 2017 indicated it did not include response to patient emergencies 2. In interview on 04-04-2018 at 5:15 pm, employee #A1, Assistant Director, confirmed the above and no other documentation was provided prior to exit. 5/23/18 T 140 T 140 410 IAC 26-8-1 PERSONNEL POLICIES AND **RECORDS** 410 IAC 26-8-1(a)(2) (a) The abortion clinic shall maintain current and accurate personnel records for all employees. Personnel records shall: (2) include personal data to include: (A) education; (B) experience; (C) date of employment; (D) a copy of current license when required; (E) evidence of participation in job-related educational and training activities; and (F) health records of employees that relate to post offer and subsequent: (i) physical examinations; (ii) tests; and (iii) immunizations. This RULE is not met as evidenced by: Based on document review and interview, the

Indiana State Department of Health

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 04/04/2018 B. WING 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 140 Continued From page 2 T 140 facility failed to ensure physical examination for 2 (S1, and S5) personnel files of 6 personnel files reviewed. Finding include: 1. Review of facility policy, Safety, revised 3/1/2018, indicated the following, the record contains the following on each employee, name and social security number, a copy of the hepatitis vaccination series status including dates and information relative to the employee's ability to receive the vaccination, copies of annual immunizations and TB testing or exam, a copy of employee accidents reports, a copy of all occupational examination results, medical testing and follow-up procedures, the employer's copy of the healthcare professional's written opinion, a copy of information provided to the healthcare professional, records of occupational exposure monitoring, records of occupational safety training and records of any other occupational medicine intervention. 2. Review of personnel files indicated the following, S1 (Medical Assistant) and S5 (Licensed Practical Nurse), lacked documentation of Physical Examination. 3. Interview on 4/3/2018, at approximately 9:50 am, with N1 (Registered Nurse, Assistant Director) confirmed the above. 5/23/18 T 168 T 168 410 IAC 26-8-3 PERSONNEL POLICIES AND RECORDS 410 IAC 26-8-3(b)

Indiana State Department of Health

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: ___ B. WING 04/04/2018 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 168 Continued From page 3 T 168 (b) The clinic shall ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and clinic policy for all health care workers including contract and agency personnel who provide direct patient care. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to follow its policy to ensure cardiopulmonary resuscitation (CPR) competence in accordance with clinic policy for 1 of 2 physician credential files reviewed and 2 of 6 employee files reviewed. 1. Review of a facility document titled Employee Safety Handbook, approved 03/01/18, indicated the Safety Manager maintains a record of each employee's training in basic CPR and BLS [basic life safety]. Further review of the document indicated the Safety Manager ensures that physicians maintain currency (sic) in Provider ACLS [advanced cardiac life support]. 2. Review of 2 physician credential files indicated file MD#2, Gynecologist, had documentation of ACLS that expired 3/20/2016, not current per facility policy. 3. Review of employee files indicated file S1, Medical Assistant, and S5, Licensed Practical Nurse, lacked documentation of CPR competence per facility policy. 3. In interview on 04-04-2018 at approximately 5:15 pm, employee #A1, Assistant Director,

Indiana State Department of Health

Indiana State Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ 04/04/2018 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 168 T 168 Continued From page 4 confirmed all the above and no other documentation was provided prior to exit. 5/30/18 410 IAC 26-11-1 INFECTION CONTROL T 206 T 206 **PROGRAM** 410 IAC 26-11-1(a)(1) (a) The clinic must do the following: (1) Provide a safe and healthful environment that minimizes infection exposure and risk to the following: (A) Patients. (B) Health care workers. (C) Persons who accompany patients. This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure a safe and healthful environment that minimizes infection exposure and risk in patients in three instances. Findings include: 1. Review of Hemocue Operating Manual indicated the following, the cover may be cleaned with alcohol or a mild soap solution. 2. On observation 4/2/2018, at approximately 2:27 pm with N1 (Registered Nurse, Assistant Director) the following was observed, a cardboard note with brownish colored droplets taped on hemocue cover. 3. Interview on 4/2/2018, at approximately 2:47 pm, with N1, confirmed there was brownish colored droplets on cardboard note taped to

Indiana State Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 04/04/2018 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY T 206 T 206 Continued From page 5 hemocue cover. 4. On observation 4/2/2018, at approximately 3:15 pm, with N1 (Registered Nurse, Assistant Director) the following was observed washer and dryer in back of storage room. Floor of room with sticky lines of material (appears to be old flooring glue) which could not be properly cleaned. Dirt and debris under shelves with sterile supplies including, gloves, cytology brushes and cotton tip applicators stored on the shelves. 5. Interview on 4/2/2018, at approximately 3:15 pm with N1, confirmed the dirty laundry was bought into storage room and loaded into machines, the floor was covered in sticky lines and sterile supplies were stored on shelves. 6. Review of facility policy, Women's Med, revised 12/6/2017, indicated the following, Inventory Management, ensures items do not expire before being used. 7. On observation 4/2/2018, at approximately 3:27 pm, with N1 (Registered Nurse, Assistant Director) the following was observed 1 box of 23G needles expired in 2001-08, containing 22 needles. 8. Interview on 4/2/2018, at approximately 3:27 pm with N1, confirmed the expired needles. 5/23/18 T 234 T 234 410 IAC 26-11-2 INFECTION CONTROL **PROGRAM** 410 IAC 26-11-2(a) (a) Sterilization of equipment and supplies must be provided, within the scope of the service

Indiana State Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WNG 04/04/2018 011128 STREET ADDREȘS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 234 T 234 Continued From page 6 offered, in accordance with acceptable standards of practice or manufacturer 's recommendations and applicable state laws and rules (to include 410 IAC 1-4, Universal Precautions). This RULE is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure facility policy was followed regarding cleaning of instruments in one facility. Findings include: 1. Review of facility policy, Safety, revised 3/1/2017, indicated the following, immerse instruments in a enzymatic cleaner/lubricant (such as Metri Clean) for 5 minutes following the manufacturer's directions for preparation and 2. Observation on 4/2/2018, at approximately 4:25 pm with N1 (Registered Nurse, Assistant Director) the following was observed. Metri Clean 2 in instrument processing area. Review of the Metri Clean 2 label indicated it was not an enzymatic cleaner. 3. Interview with on 4/2/2018, at approximately 4:25 pm, with N2 (Medical Assistant) confirmed Metri Clean 2 was used to clean instruments. 4. Interview on 4/2/2018, at approximately 4:34 pm, with N1 confirmed Metri Clean 2 instrument cleaner was not enzymatic.

Indiana State Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: ___ 04/04/2018 R WING 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 322 T 322 Continued From page 7 4/5/18 T 322 410 IAC 26-16-1 PHARMECEUTICAL T 322 **SERVICES** 410 IAC 26-16-1(3)(A) The clinic must provide drugs and biologicals in a safe and effective manner in accordance with accepted professional practice. The clinic must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug: (i) handling; (ii) storing; (iii) labeling; (iv) dispensing; and (v) administration according to established clinic policies and acceptable standards of practice. This RULE is not met as evidenced by: Based on document review, observation and interview the facility failed to implement policy related to medications in one facility. Findings include: Review of facility policy, Medical, revised 12/7/2017, indicated the following, every staff member removes conditions that are unsafe to patients immediately, and then notifies their supervisor. Act first, communicate second. Such

Indiana State Department of Health STATE FORM

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: _ 04/04/2018 B WNG 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 322 Continued From page 8 T 322 unsafe conditions include: expired drugs or laboratory reagents, improper staff actions, faulty equipment, etc... The Head Nurse oversees that all nursing staff adhere to best practices and standards of care in the handling, packaging, administering and handing out of medication. ...discards all drugs that will expire in the coming month. 2. On observation 4/2/2018, at approximately 3:27 pm, in the medication room, with N1 (Registered Nurse, Assistant Director) the following was observed. 4 vials of diazepam 5mg/ml, 10 ml, 2 expired 9/2017, and 2 expired 12/2017, not included in count. Inside a box marked needles was a plastic bag which contained blue paper taped shut which contained 5 vials of Gentamicin 80 mg/2ml, expired 3/1/2015. 3. Interview on 4/2/2018, at approximately 3:47 pm, with N1 confirmed the above. 4/25/18 T 404 T 404 410 IAC 26-17-3 PHYS. PLANT, MAINT., EQUIP., ENVIR., SAFETY 410 IAC 26-17-3(2) The condition of the physical plant and the overall clinic environment must be developed and maintained in such a manner that the safety and well-being of patients is assured as follows: (2) No condition may be created or maintained that may result in a hazard to: (A) patients; (B) authorized visitors; or (C) employees.

Indiana State Department of Health STATE FORM

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WNG 04/04/2018 011128 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 404 T 404 Continued From page 9 This RULE is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have appropriate equipment to use a caustic chemical substance according to manufacturer's instructions in 3 instances. Findings include: 1. On 04-02-2018 at approximately 4:35 pm, in the presence of employee #A1, Assistant Director), it was observed in the product of conception processing area a chemical, MetriClean 2, was stored. 2. In interview on the above date and time, employee #A1 indicated the chemical was used when processing product of conception. 3. Review of the label on the bottle of MetriClean 2, a caustic chemical, indicated there were manufacturer's instructions which indicated First Aid Measures: EYES - Flush immediately with water for 20-30 minutes. 4. Review of the OSHA (Occupational and Safety Health Administration) hazard communication program indicated in general standard 1910.151 when necessary, facilities for drenching or flushing the eyes shall be provided within the work area for immediate emergency use. In applying these general terms, OSHA would consider the guidelines set by such sources as American National Standards Institute (ANSI) Z358.1 -1998, Emergency Eyewash and Shower Equipment, which indicated in section 7.4.4, that evewash facilities are to be located to require no more than 10 seconds to reach but where a

Indiana State Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 04/04/2018 011128 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 N ARLINGTON AVE WOMEN'S MED GROUP PROFESSIONAL CORPORAT INDIANAPOLIS, IN 46219 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) T 404 T 404 Continued From page 10 strong acid or a caustic chemical is used, the unit should be immediately adjacent to the hazard. 5. On the above-stated date, time, place, and presence of employee #A1, it was observed there was no eyewash facility immediately adjacent to the area where the caustic chemical was used. 6. On 04-02-2018 at approximately 4:40 pm, in the presence of employee #A1, Assistant Director, it was observed in Operating Room 1 there was an electrical outlet on a wall which had a broken plug receptacle. This posed an electrical hazard if an electrical plug was not properly seated in the receptacle. 7. On 04-02-2018 at approximately 4:40 pm, in the presence of employee #A1, it was observed in Operating Room 1 on another wall, there was an alcohol-based hand sanitizer (ABHS) on the wall directly over an electrical outlet. This posed a fire hazard if the flammable alcohol in the sanitizer was sprayed or dropped into the electrical ignition source.

Indiana State Department of Health

	SURVEYOR NOTES WORKSHEET
Facility Name: <u>4</u>	muis / Wical group Surveyor Name: Jack I. Cohen
gevider Number:	Surveyor Number: 17294 Discipline: Med Sur
Observation Dates	: From 42 2018 To 4-4-2018
TAG/CONCERNS	DOCUMENTATION
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4.4	95.4 (15) 5-545 (25) 9-5 (8)
Form CM5-807 (07/95)	

Women's Med Group Abortion Clinic Administrative Document Request

Jack 1 Cohen 4-2-2018

List of credentialed staff for
List of non-nursing Personnel for
20028 - Ownership—copy of articles of incorporation
10094 - Quality assurance plan and documents to include all services/function/contracts
*0078 - □ List of contracts with scope and nature of services
★ 00.40 - ☐ Constitution and bylaws of governing body (if applicable)
0026 - Minutes of governing body (if applicable) 2007
AMIS Process for reporting health professionals
₩7092 Written policy addressing internal review of unusual occurrences and disasters
is complete to 12 -6 -2017
Medical Staff Rules including; _approved_12-6-2017 10086 - Procedures for emorgency, initial pentment, trapsfer
10086 - Procedures for emorgency, initial treatment, transfer
ل ير ال ال ال ال ال ال ال ال ال ال ال ال ال
nl/k n134 n182. Authentication of orders, who may take verbal orders
10260 - □ Policy and procedure for communication with and timely response of physicians
concerning a pt emergency
Anna T Health care worker practice problems
0.172 Develoin Credentialing (if physician performs procedures): verify admitting privilege
in writing OR a written agreement with another physician with admitting privileges. The
-document(s) must be present in the clinic.
Medical records policies including;
₩0108 - □ Policies assuring documentation of care and services provided
¥0110 - □ Policies for safeguarding records from sources of damage
★0112 - ☐ Maintenance of records for appropriate time frame
* 0118 - L3 Authentication and sederity of record
¥ 0122 - ☐ Use of plain paper fax
¥0126 - □ Confidentiality
(→ 0126 - □ Release of information
10252 - Laundry policies
70300 - Dietary policies (if applicable) WA
Lab policies including;
1.0310 - CLIA certificate or waived
1316 - □ Quality control and QA policies for complexity of tests
•
Physical plant/ Safety policies including;
#0406¥0416 - □ Preventative maintenance policies/logs
> 0418 - □ Repairs and electrical leakage checks
0262, 0426. 0426 - □ Housekeeping and infectious waste policies
₹0406, 0₹0 - ☐ Equipment inspection
(1903, 19630 - ☐ Vermin Control
0422, 0124 - ☐ Building operations
↑0430 - □ Chemical substance use/storage
1430 - ☐ Surgical waste disposal
10430 - Cheneral housekeeping
0.416, 0.428 - Fire exertrol plan AND Evidence of state or local fire inspection
1 0440 Emergency/disaster preparedness
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leg doc (A) 4-2 930 - Reviewed 4-2 * - Reviewed 4-4

Facility Name Women's Med Clinic
Surveyor garles Oblew Date 4-2-2018

ABORTION CLINIC DOCUMENT REQUEST - CREDENTIAL FILE REVIEW

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	Women's Med linic surveyor Janual Collections
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Indiana State Department of Health Personnel/physician identifier Table

Name of abortion clinic: Wruly	Medical Group
Date of Survey 4-2-2018	
Staff/Physician Name - RN - 455+ Dir	Number assigned by surveyor





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SURVEYOR NOTES WORKSHEET

Facility Name	Women's Medical Down Surveyor Name Vivian J. Smart R. N.
Provider Number	Oll A Surveyor Number 30317 Discipling DUNC
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SURVEYOR NOTES WORKSHEET

Vivian Smars Kn PING 38313

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SURVEYOR NOTES WORKSHEET

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SURVEYOR NOTES WORKSHEET

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Wenners Medical Groups

Valida Brand

Abortion Clinic Nursing Document Request

	Patient list/register for Communication
	List of all Nursing Personnel including species for
	Complaint Log for No
	Incident Reports for 12 puts
	Personnel policies including;
	☑ Policy for control of communicable diseases includes specific to TB
Land Control	☑ Policy for control of communicable diseases includes specific to TB ☑ Orientation and training of new employees, contract and agency personnel
phone.	EFCPR policy (Account to the Control of the Control
Len	E CPR policy Annual in-service requirements
V	Annual in-service requirements [Annual competency for nursing and other personnel performing lab tests Patient care/nursing policies and procedures including; [Composition of and meeting minutes for the patient care personnel committee 76/66 years [Reliable method of ID] Instruction for follow up care and transportation—to include counseling, RH type and administration of Rhogam [Reporting of post procedure complications and follow up]
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	☑ Reliable method of ID
محمزه	Instruction for follow up care and transportation—to include counseling, RH type and
	administration of Rhogam
V_{I}	Reporting of post procedure complications and follow up
1/-	Cleaning and sterilization of reusable equipment
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/	Infection control program and policies including;
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1	Composition and meeting influtes of infection Control Program [Provision for active and effective Infection Control Program
	\cdot :
	Sterilization policies and procedures including;
ممرث	Management of sterile supplies
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ABORTION CLINIC NURSING TOUR

FACILITY Women's Medical Group SURVEYOR VIVIAN Smart KN PHNS 38315
MED DIR! MANAGER! TOUR: DATE 1/2/29 PTIME 2:26 P.M
STAFFING: R.N LPN Tech Ratio:
Traffic pattern Dressing areas/staff/patients Adequate supplies/storage Clean utility Clean utility NUMBER OF PROCEDURE ROOMS Soiled utility Linen Storage Handwashing sinks/toilets preventive maintenance
PROCEDURE/ANESTHESIA/RECOVERY AREAS: Scrub area Dress code adherence Vo Potens Emergency call system Oxygen/humidifier bottles Resuscitation equipment VA Defibrillators (if IV Sedation is used) NA Cardiac Monitors (if IV Sedation is used) AE D Suction Equipment (if IV Sedation is used) Medical staff (if IV Sedation is used) NA Cardiac Monitors (if IV Sedation is used) Medication and narcotic storage/drug areas/stock supplies
OTHER: Clean/dirty instrument/sterilization areas Sterilizers Chemical/biological indicators Waste disposal: All types
COMMENTS/INTERVIEWS: Sale noon used for even room, pelver Conferm 2:47 has N conducted more a Herrary brush. Card board was a Herrary could was brush. Card board was in Herrary could was brush. Card board was 12:49 - Herrary in booked altrace room. (15 pm Washen and Drug in booked altrace room. Chaharad laundry browshe to were when I staile supplies are kept Sterile glows, contributions brush. Cotton turbon applicant on full of
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Indiana State Department of Health Patient/Record Identifier Table

Name of abortion clinic: Women's Medical Group

Date of survey: 4/2/2018

Type of survey: Storte

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ABORTION CLINIC MEDICAL RECORD REVIEW

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Form 56115 - Available Counseling after an Abortion	1									

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Indiana State Department of Health
CLINIC Worming Med Center Character Staffing Dates 3/19/18-3/23/18
Survey Dates: 3 42/18 10 3123/18 4/4/18
ONE WEEK STAFFING PATTERN WORKSHEET FOR EACH CLINIC AREA
hast FTE for all direct care mursing staff actually on duty for the dates shown.
Shift Sunday Monday Tuesday Wednesday Thursday Friday Saturday RN LPN O RN
Tensus 0 0 0 18 26 37 0
NURSING COMPLIMENT DATA
NURSING STAFF ASSIGNED TO DIRECT PATIENT CARE NURSING STAFF ASSIGNED TO INDIRECT PATIENT CARE (FTES)
OTHER (SPECIFY) NURSING NSG. NSG. SUP.
SHIFT RN LPN MA SHIFT RN DAY 0/25 0/25
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IOTAL.
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Above is to be calculated in full-time equivalents (FTEs). Part IV totals is Obtained by adding parts I, II and III.
-Innic Director Assistant Director Date Nurse Surveyor Date
Signature of Staff Physician Date

Indiana State Department of Health Personnel Document Review

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Guideline for Disinfection and Sterilization in Healthcare Facilities (2008)

On This Page

- Overview
- Sterilization cycle verification
- Physical facilities
- Cleaning
- Packaging
- Loading
- Storage
- Monitoring

Sterilizing Practices

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Ensuring consistency of sterilization practices requires a comprehensive program that ensures operator competence and proper methods of cleaning and wrapping instruments, loading the sterilizer, operating the sterilizer, and monitoring of the entire process. Furthermore, care must be consistent from an infection prevention standpoint in-all patient-care settings, such as hospital and outpatient facilities.

∧ Top of Page

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Biological and chemical indicator testing is also done for ongoing quality assurance testing of representative samples of actual products being sterilized and product testing when major changes are made in packaging, wraps, or load configuration. Biological and chemical indicators are placed in products, which are processed in a full load. When three consecutive cycles show negative biological indicators and chemical indicators with a correct end point response, you can put the change made into routine use^{811-814,958}. Items processed during the three evaluation cycles should be quarantined until the test results are negative.

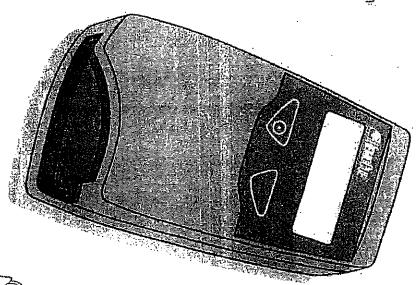
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Section 15. Regulatory Information

U.S. Federal Regulations:

EPA SARA 311/312 Hazard Classification: Acute Health

EPA SARA 313: This Product Contains the Following Chemicals Subject to Annual Release Reporting Requirements Under SARA Title III, Section 313 (40 CFR 372): None

Protection Of Stratospheric Ozone: This product is not known to centain or to have been manufactured with ozone depleting substances as defined in 40 CFR Part 82, Appendix A to Subpart A.

CERCLA SECTION 103: This product has a reportable quantity (RQ) of 20,000 lbs based on the RQ for potassium hydroxide of 1000 lbs. Many states have more stringent release reporting requirements. Report spills required under federal, state and local regulations.

Canadian Regulations

National Pollutant Release Inventory (NPRI): This Product Contains the Following Chemicals Subject to Annual Release Reporting Requirements NPRI: None

This product has been classified in accordance with the hazard criteria of the Controlled Products Regulations and the MSDS contains all the information required by the Controlled Products Regulations

International Inventories

US EPA TSCA Inventory: All of the components of this productive listed on the Toxic Substances Control Act (TSCA) Chemical Substances Inventory or exempt.

Canadian Environmental Protection Act: All of the components in this product are listed on the Domestic Substances List (DSL) or exempt.

Australia: All of the components in this product are listed on the Australian Inventory of Chemical Substances (AICS) or exempt.

China: All of the components in this product are listed on the Inventory of Existing Chemical Substances in China (IECSC) or exempt.

New Zealand: All of the components in this product are listed on the New Zealand inventory of Chemicals (NZIoC) or exempt.

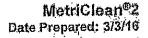
Section 16. Other Information

NFPA Rating: Fire: 1

Health: 3

Instability: 0

The information and recommendations set forth herein are taken from sources believed to be accurate as of the date of preparation, however, METREX® RESEARCH makes no warranty with respect to the accuracy or suitability of the recommendations, and assumes no liability to any use thereof.





Carcinogen: None of the components is listed as a carcinogen or potential carcinogen by IARC, NTP, ACGIH, or OSHA.

Acute Toxicity Values

Potassium Hydroxide, LD50 Oral Rat 273 mg/kg. Acrylic Acid Polymer Sodium Salt. No data available

Triethanolamine: LD50 Oral Rat >4000 mg/kg; LD50 Dermal Rabbit >2000 mg/kg

Section 12. Ecological Information

This product is not classified as aquatically toxic based on the GHS criteria for aquatic toxicity.

Toxicity:

Potassium Hydroxide: LC50 mosquito fish 80 mg/L/96

Acrylic Acid Polymer Sodium Salt: EC50 ceriodaphnia 162 mg/L/48 hr

Triethanolamine: LC50 fathead minnow 1800-11,800 mg/L/96 hr; LC50 daphnia magna 739-2038 mg/L/24 hr; ErC50 algae 216-750 mg/L/72 hr

Persistence and degradability: Triethanolamine is readily biodegradable in screening tests. Acrylic Acid Polymer Sodium Salt is not readily biodegradable. Biodegradation is not applicable to inorganic substances such as potassium hydroxide.

Bioaccumulative Potential: Triethanciamine has a low potential to bioaccumulate.

Mobility in Soil: Triethanolamine is expected to have very nigh mobility in soil.

Other Adverse Effects: Releases of large amounts to waterways will affect the pH of the water and may have an adverse effect on aquatic organisms.

Section 13. Disposal Considerations

Solution Disposal: Unused product or wastes resulting from the use of this product may be disposed of according to applicable Federal. State, or local procedures. Unused product would be classified as a RCRA hazardous waste, characteristic corrosivity.

Container Disposal: Nonrefillable container. Do not reuse or refill this container. Offer for recycling, if available, if recycling is not available, discard in accordance with hospital policy.

Section 14. Transport Information.

	UN Number	UN Proper Shipping Name	Hazard Class(s)	Packing Group	Environmental Hazards
US DOT	UN1814	Potassium Hydroxide Solution	.8	PGII	None
EU ADR/RID	UN1814	Potassium Hydroxide Solution	8 \	PGII	None
IMDG	UN1814	Potessium Hydroxide Solution	8	PG II	None
IATA/ICAO	UN1814	Potassium Hydroxide Solution	8	PG II	None





Skin Protection: Wear protective clothing if needed to prevent skin contact. Contaminated clothing must be immediately removed and laundered before re-use.

Hygiene measures: Suitable eye wash and washing facilities should be available in the work area.

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Appearance:	Clear blue-green liquid	Oder:	Fresh, clean scent
Odor Threshold:	Not available	pH:	13.0 -14.0
Melting/Freezing Point:	Not available	Boiling Point/Range:	Not determined
Flash Point:	Not flammable	Evaporation Rate:	Not available
Flammability: (Solid, Gas)	Not applicable	Flammability Limits:	Not applicable
Vapor Pressure: Relative Density:	Same as water >1.025	Vapor Density: Solubilities:	Not available Completely soluble in water
Partition Coefficient: (N-Octanol/Water)	Not available	Autolgnition Temperature:	Not flammable
Decomposition Temperature:	Not available	Viscosity:	Not available

Section 10. Stability and Reactivity

Reactivity: None known. Chemical Stability: Stable.

Possibility of Hazardous Reactions: May react with chemically reactive metals such as aluminum, zinc

or magnesium to release hydrogen gas, which is flammable and explosive.

Conditions to avoid: Excessive heat.

Incompatible Materials: Strong oxidizing agents, acids reactive metals.

Hazardous decomposition products: Thermal decomposition will produce carbon monoxide, carbon

dioxide, nitrogen oxides, amines.

Section 11. Toxicological Information

Potential Health Effects:

Inhalation: Vapors and mists may cause severe irritation of the eyes, nose and throat. High concentrations may cause lung damage.

Skin Contact: Corrosive. May cause severe irritation or burns.

Eye Contact: Corresive. May cause severe irritation with burns and permanent eye damage.

Ingestion: Harmful or fatal if swallowed. Causes burns to the mouth, throat and intestinal tract.

Chronic Hazards: Prolonged overexposure to dilute solutions may cause dermatitis.



Special Protective Equipment and Precautions for Fire-fighters: Firefighters should wear positive pressure self-contained breathing apparatus and full protective clothing for fires in areas where chemicals are used or stored:

Section 6: Accidental Release Measures.

Personal precautions, Protective equipment, and Emergency procedures: Wear appropriate protective clothing and equipment.

Methods and Materials for Containment and Cleaning up: Neutralize spill with a dilute weak acid, such as acetic acid or use alkali spill kit. Collect material with an inert absorbent material and place in appropriate, labeled container for disposal.

Section 7. Handling and Storage

Precautions for Safe Handling: Do not get in eyes, on skin or on clothing. Wear appropriate protective clothing when handling. Wash thoroughly with soap and water after handling and before eating, drinking, chewing guin, using tobacco or using the toilet, immediately remove and wash contaminated clothing before reuse. Use in accordance with label directions.

Conditions for Safe Storage, including any incompatibilities: Store in a cool area.

Empty containers retain product residues and may be hazardous. Do not flame cut, drill, weld, etc. on or near empty containers, even empty.

Section 8. Exposure Controls / Personal Protection

Exposure Limits

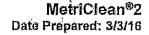
Chemical	Exposure Limit
Potassium Hydroxide	2 mg/m3 Ceiling ACGIH TLV
Acrylic Acid Polymer Sodium Salı	None Established
Triethanolamine	5 mg/m3 TWA ACGIH TLV

Appropriate Engineering Controls: For operations where the exposure limits may be exceeded, mechanical ventilation such as local exhaust may be needed to minimize exposure.

Respiratory Protection: None under normal use conditions with adequate ventilation. For operations where the occupational exposure limits are exceeded, a NIOSH approved respirator with an organic vapor/dust/mist cartridges or supplied air respirator is recommended. Equipment selection depends on contaminant type and concentration. Select in accordance with 29 CFR 1910.134 and good industrial hygiene practice. For firefighting, use self-contained breathing apparatus.

Hand protection: Protective gloves such as nitrile are recommended.

Eye Protection: Splash proof goggles and face shield recommended.





IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to-do. Continue rinsing.

Immediately call a POISON CENTER.

Storage and Disposal Store locked up.

Dispose of contents and container in accordance with local and national regulations.

Section 3. Composition/Information On Ingredients

Component	CAS No.	Amount
Water	7732-18-5	7.0-90%
Potassium Hydroxide	1310-58-3	1-5%
Acrylic Acid Polymer Sodium Salt	i Proprietary	1-5%
Triethanolamine	102-71-6	1-5%

Section 4. First Aid Measures

Eye Contact: Hold eye open and rinse slowly and gently with water for 20-30 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing. Get immediate medical attention.

Skin Contact: Immediately remove contaminated clothing. Flush all affected and exposed areas with plenty of water for at least 15-20 minutes. If skin irritation develops and persists, seek medical attention. Launder clothing before reuse. Discard items that cannot be thoroughly decontaminated, like leather shoes and belts.

Inhalation: Move to fresh air if effects occur and seek medical attention if effects persist. If not breathing or breathing is difficult, give oxygen or artificial respiration. Get immediate medical attention.

Ingestion: If swallowed, get immediate medical advice by calling a Poison Control Center or hospital emergency room. If advice is not available, take victim and product container to the nearest emergency treatment center or hospital. Do NOT induce vorniting: If the victim is alert, rinse their mouth with water. Do not attempt to give anything by mouth to an unconscious person.

Most important symptoms and effects, acute and delayed: Causes skin burns and eye damage. Harmful or fatal if swallowed. Causes burns to the mouth; throat and intestinal tract. Inhalation of mists or vapors may cause severe irritation of the eyes, nose and throat. High concentrations may cause lung damage.

Indication of immediate medical attention and special treatment, if needed: immediate medical attention is required for all routes of exposures.

Section 5. Fire Fighting Measures

Suitable (and Unsuitable) Extinguishing Media: Use any media that is suitable for the surrounding fool fire exposed containers with water.

ing from the Chemical: May react with chemically reactive metals such as to release hydrogen gas, which is flammable and explosive.





MATERIAL SAFETY DATA SHEET

Section 1. Product And Company Identification

Product Name: MetriClean®2

Product Use: Low foaming detergent

Manufacturer:

METREX® RESEARCH

1717 W. Collins Ave. Orange, CA 92867

U.S.A.

Information Phone Number: 1-800-841-1428 (Customer Service)

Chemical Emergency Phone Number (Chemical Spills, Leaks, Fire; Exposure or Accident only); CHEMTREC 1-800-424-9300 (In the US) 1-703-527-3887 (Outside the US)

SDS Date Of Preparation/Revision: 3/3/16

Section 2. Hazards Identification

GHS / HAZCOM 2012 Classification:

Skin Damage Category 1B Eye Damage Category 1

Label Elements

Dangerl



Hazard Phrases

Causes severe skin burns and eye damage

Prevention:

Do not breathe mists.

Wash thoroughly after handling.

Wear protective gloves, protective clothing, eye protection and face protection

Response:

IF SWALLOWED: Rinse mouth. Do NOT induce vomiting.

Immediately call a POISON CENTER.

IF ON SKIN (or hair): Take off immediately all contaminated clothing. Rinse skin with soap and water. Wash contaminated clothing before reuse.

Immediately call a POISON CENTER.

IF INHALED: Remove person to fresh air and keep comfortable for breathing.

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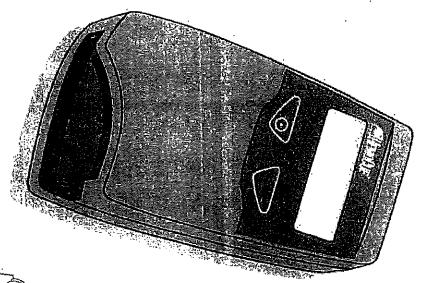
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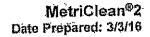
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Section 15 Regulatory Information

U.S. Federal Regulations:

EPA SARA 311/312 Hazard Classification: Acute Health

EPA SARA 313: This Product Contains the Following Chemicals: Subject to Annual Release Reporting Requirements Under SARA Title III, Section 313 (40 CFR 372): None

Protection Of Stratospheric Ozone: This product is not known to contain or to have been manufactured with ozone depleting substances as defined in 40 CFR Part 82, Appendix A to Subpart A.

CERCLA SECTION 103: This product has a reportable quantity (RQ) of 20,000 lbs based on the RQ for potassium hydroxide of 1000 lbs. Many states have more stringent release reporting requirements. Report spills required under federal, state and local regulations. ٠,

Canadian Regulations

National Pollutant Release Inventory (NPRI): This Product Contains the Following Chemicals Subject to Annual Release Reporting Requirements NPRI: None

This product has been classified in accordance with the hazard criteria of the Controlled Products Regulations and the MSDS contains all the information required by the Controlled Products Regulations

International Inventories

US EPA TSCA Inventory: All of the components of this product are keed on the Toxic Substances Control Act (TSCA) Chemical Substances Inventory or exempt.

Canadian Environmental Protection Act: All of the components in this product are listed on the Domestic Substances List (DSL) or exempt.

Australia: All of the components in this product are listed on the Australian Inventory of Chemical Substances (AICS) or exempt.

China: All of the components in this product are listed on the Inventory of Existing Chemical Substances in China (IECSC) or exempt.

New Zealand: All of the components in this product are listed on the New Zealand Inventory of Chemicals (NZIoC) or exempt.

Section 16. Other information

NFPA Rating: Fire: 1

Health: 3

instability: 0

The information and recommendations set forth herein are taken from sources believed to be accurate as of the date of preparation, however, METREX® RESEARCH makes no warranty with respect to the accuracy or sultability of the recommendations, and assumes no liability to any use thereof.



Carcinogen: None of the components is listed as a carcinogen or potential carcinogen by IARC, NTP. ACGIH, or OSHA.

Acute Toxicity Values

Potassium Hydroxide: LD50 Oral Rat 273 mg/kg. Acrylic Acid Polymer Sodium Salt: No data available

Triethanolamine: LD50 Oral Rat >4000 mg/kg; LD50 Dermal Rabbit >2000 mg/kg

Section 12. Ecological Information

This product is not classified as aquatically toxic based on the GHS criteria for aquatic toxicity.

Toxicity:

Potassium Hydroxide: LC50 mosquito fish 80 mg/L/98

Acrylic Acid Polymer Sodium Salt: EC50 cenodaphnia 162 mg/L/48 hr

Triethanolamine: LC50 fathead minnow 1800-11,800 mg/L/96 hr; LC50 daphnia magna 739-2038

mg/L/24 hr, ErC50 algae 216-750 mg/L/72 hr

Persistence and degradability: Triethanolamine is readily biodegradable in screening tests. Acrylic Acid Polymer Sodium Salt is not readily biodegradable. Biodegradation is not applicable to inorganic substances such as potassium hydroxide.

Bioaccumulative Potential: Triethanciamine has a low potential to bioaccumulate.

Mobility in Soil: Triethanolamine is expected to have very nigh mobility in soil.

Other Adverse Effects: Releases of large amounts to waterways will affect the pH of the water and may have an adverse effect on equatic organisms.

Section 13. Disposal Considerations

Solution Disposal: Unused product or wastes resulting from the use of this product may be disposed of according to applicable Federal, State or local procedures. Unused product would be classified as a RCRA hazardous waste, characteristic corrosivity.

Container Disposal: Nonrefillable container. Do not retise or refill this container. Offer for recycling, it available if recycling is not available, discard in accordance with hospital policy.

Section 14. Transport Information.

al .	UN Number	UN Proper Shipping Name	Hazard Class(s)	Packing Group	Environmental Hazards
US DOT	UN1814	Potassium Hydroxide Solution	8	PG II	None
EU ADR/RID	UN1814	Potassium Hydroxide Solution		PG II	None
IMDG	UN1814	Potassium Hydroxide Solution		PG II	None
IATA/ICAO	UN1814	Potassium: Hydroxide Solution		PG II	None



Skin Protection: Wear protective clothing if needed to prevent skin contact. Contaminated clothing must be immediately removed and laundered before re-use.

Hygiene measures: Suitable eye wash and washing facilities should be available in the work area.

Section 9. Physical and Chemical Properties

Appearance:

Clear blue-green

Oder:

Fresh, clean scent

liquid

pH:

13.0 -14.0

Odor Threshold: Melting/Freezing Not available Not available

Boiling

Limits:

Not determined

Point:

...

Flash Point:

Not flammable

Point/Range: Evaporation Rate:

Not available

Flammability: (Solid,

Not applicable

Flammability

Not applicable

Gas) Vapor Pressure:

Same as water

Vapor Density:

Not available

Relative Density:

>1.025

Solubilities:

Completely soluble in

water

Partition Coefficient:

(N-Octanol/Water) Decomposition

Temperature:

Not available

Autoignition Temperature: Not flammable

Not available

Viscosity:

Not available

Section 10. Stability and Reactivity

Reactivity: None known... Chemical Stability: Stable.

Possibility of Hazardous Reactions: May react with chemically reactive metals such as aluminum, zinc

or magnesium to release hydrogen gas, which is flammable and explosive.

Conditions to avoid: Excessive heat.

Incompatible Materials: Strong oxidizing agents, acids reactive metals.

Hazardous decomposition products: Thermal decomposition will produce carbon monoxide, carbon

dioxide, nitrogen oxides, amines.

Section 11. Toxicological information

Potential Health Effects:

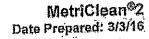
Inhalation: Vapors and mists may cause severe irritation of the eyes, nose and throat. High concentrations may cause lung damage.

Skin Contact: Corrosive. May cause severe irritation or burns.

Eye Contact: Corrosive. May cause severe irritation with burns and permanent eye damage.

Ingestion: Harmful or fatal if swallowed. Causes burns to the mouth, throat and intestinal fract.

Chronic Hazards: Prolonged overexposure to dilute solutions may cause dermatitis.





Special Protective Equipment and Precautions for Fire-fighters: Firefighters should wear positive pressure self-contained breathing apparatus and full protective clothing for fires in areas where chemicals are used or stored.

Section 6: Accidental Release Measures

Personal precautions, Protective equipment, and Emergency procedures: Wear appropriate protective clothing and equipment.

Methods and Materials for Containment and Cleaning up: Neutralize spill with a dilute weak acid, such as acetic acid or use alkali spill kit. Collect material with an inert absorbent material and place in appropriate, labeled container for disposal.

Section 7. Handling and Storage

Precautions for Safe Handling: Do not get in eyes, on skin or on clothing. Wear appropriate protective clothing when handling. Wash theroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet, immediately remove and wash contaminated clothing before reuse. Use in accordance with label directions.

Conditions for Safe Storage, including any incompatibilities: Store in a cool area.

Empty containers retain product residues and may be hazardous. Do not flame cut, drill, weld, etc. on or near empty containers, even empty.

Section 8. Exposure Controls / Personal Protection

Exposure Limits

T	Chemical	Exposure Limit
\vdash	Potassium Hydroxide	2 mg/m3 Ceiling AGGIH TLV
F	Acrylic Acid Polymer Sodium Salt	None Established
	Triethanolamine	5 mg/m3 TWA ACGIH TLV
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Appropriate Engineering Controls: For operations where the exposure limits may be exceeded, mechanical ventilation such as local exhaust may be needed to minimize exposure.

Respiratory Protection: None under normal use cendations with adequate ventilation. For operations where the occupational exposure limits are exceeded, a NIOSH approved respirator with an organic vapor/dust/mist cartridges or supplied air respirator is recommended. Equipment selection depends on contaminant type and concentration. Select in accordance with 29 CFR 1910.134 and good industrial hygiene practice. For firefighting, use self-contained breathing apparatus.

Hand protection: Protective gloves such as nitrile are recommended.

Eye Protection: Splash proof goggles and face shield recommended.



IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing: Immediately call a POISON CENTER.

Storage and Disposal Store locked up

Dispose of contents and container in accordance with local and national regulations.

Section 3, Composition/Information On Ingredients

Component	CAS No.	Amount
Component Water	7732-18-5	70-90%
Potassium Hydroxide	1310-58-3	1-5%
Acrylic Acid Polymer Sodium Salt	Proprietary	. : 1-5%
Triethanolamine	102-71-6	1-5%

Section 4. First Aid Measures

Eye Contact: Hold eye open and rinse slowly and gently with water for 20-30 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing. Get immediate medical attention.

Skin Contact: Immediately remove contaminated clothing. Flush all affected and exposed areas with plenty of water for at least 15-20 minutes. If skin irritation develops and persists, seek medical attention. Launder clothing before reuse. Discard items that cannot be thoroughly decontaminated, like leather shoes and belts.

Inhalation: Move to fresh air if effects occur and seek medical attention if effects persist. If not breathing or breathing is difficult, give oxygen or artificial respiration. Get immediate medical attention:

Ingestion: If swallowed, get immediate medical advice by calling a Polson Control Center or hospital emergency room. If advice is not available, take victim and product container to the nearest emergency treatment center or hospital. Do NOT induce vomiting. If the victim is alert, rinse their mouth with water. Do not attempt to give anything by mouth to an unconscious person.

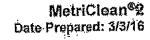
Most important symptoms and effects, acute and delayed: Causes skin burns and eye damage. Harmful or fatal if swallowed. Causes burns to the mouth, throat and intestinal tract. Inhalation of mists or vapors may cause severe irritation of the eyes, nose and throat. High concentrations may cause lung damage.

Indication of immediate medical attention and special treatment, if needed: immediate medical attention is required for all routes of exposures.

Section 5. Fire Fighting Measures

Suitable (and Unsuitable) Extinguishing Media: Use any media that is suitable for the surrounding fire. Cool fire exposed containers with water.

Specific Hazards Arising from the Chemical: May react with chemically reactive metals such as aluminum, zinc or magnesium to release hydrogen gas, which is flammable and explosive.





MATERIAL SAFETY DATA SHEET

Section 1. Product And Company Identification

Product Name: MetriClean®2

Product Use: Low foaming detergent

Manufacturer:

METREX® RESEARCH 1717 W. Collins Ave.

Orange, CA 92867

U.S.A.

Information Phone Number: 1-800-841-1428 (Customer Service)

Chemical Emergency Phone Number (Chemical Spills, Leaks, Fire, Exposure or Accident only): CHEMTREC 1-800-424-9300 (in the US) 1-703-527-3887 (Outside the US)

SDS Date Of Preparation/Revision::3/3/16

Section 2. Hazards Identification

GHS / HAZCOM 2012 Classification:

Skin Damage Category 1B Eye Damage Category 1

Label Elements

Danger!



Hazard Phrases

Causes severe skin burns and eye damage

Prevention:

Do not breathe mists.

Wash thoroughly after handling.

Wear protective gloves, protective clothing, eye protection and face protection.

Response:

IF SWALLOWED: Rinse mouth. Do NOT induce vomiting.

Immediately call a POISON CENTER.

IF ON SKIN (or hair). Take off immediately all contaminated clothing. Rinse skin with scap and water.

Wash contaminated clothing before reuse.

Immediately call a POISON CENTER.

IF INHALED: Remove person to fresh air and keep comfortable for breathing. Immediately call a POISON CENTER.

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